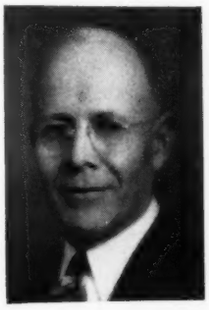
The Journal

of the Michigan State Medical Society

Volume 49 | January, 1950 | Number 1

z G. ALEXANDER, M.D.
Chicago, Illinois



WALTER C. ALVAREZ, M.D.
Rochester, Minnesota

WM. L. BENEDICT, M.D.
Rochester, Minnesota

MARION A. BLANKENHORN, M.D.
Cincinnati, Ohio

F. BAYARD CARTER, M.D.
Durham, North Carolina

ERICK A. COLLER, M.D.
Ann Arbor

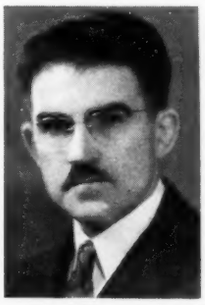
GEORGE CRILE, JR., M.D.
Cleveland, Ohio

RICHARD FREYBERG, M.D.
New York City

J. MASON HUNDLEY, JR., M.D.
Baltimore, Maryland

PLINN F. MORSE, M.D.
Detroit

IAN P. PRICE, M.D.
reece, South Carolina



LEO G. RIGLER, M.D.
Minneapolis, Minnesota

FRANCIS E. SENEAR, M.D.
Chicago, Illinois

ISADORE SNAPPER, M.D.
New York City

WALTMAN WALTERS, M.D.
Rochester, Minnesota

Michigan Postgraduate Clinical Institute
March 8-9-10, 1950—Detroit

(See page 101-105)

Contributors to this Issue

JOHN M. DORSEY, M.D.

F. G. EBAUGH, M.D.

ALFRED E. EYRES, M.D.

L. GALDONYI, M.D.

L. E. HIMLER, M.D.

ARNOLD S. JACKSON, M.D.

H. J. LARSSON, M.D. E. F. SLADEK, M.D. J. F. WENZEL, M.D.

Table of Contents

President's Address.
E. F. Sladek, M.D. 49

Experiences with Routine Rh Typing in Obstetrics.
Charles W. Aldridge, M.D., and *Robert M. Campbell, M.D.* 51

Extra-abdominal Causes Producing Acute Abdominal Signs.
Russell Barnes, M.D. 59

Acute Surgical Conditions of the Abdomen.
Arnold S. Jackson, M.D. 64

Recto-urethral Fistula.
J. F. Wenzel, M.D., and *E. A. Jenkins, M.D.* 67

Mental Illness.
Alfred E. Eyres, M.D. 69

The Place of Psychiatry in Industry.
L. E. Himler, M.D. 75

Iatrogenicity in Medicine.
Franklin G. Ebaugh, M.D. 79

Observations on a Recent Journey in Sweden.
B. Hjalmar Larsson, M.D. 85

Rehabilitation of the Hard-of-Hearing School Child.
L. Galdonyi, M.D. 89

Family Guidance.
John M. Dorsey, M.D. 92

President's Page:
Personalized Therapeutics 97

Editorial:
Greetings for 1950 98
Vicious Publicity 98
Public Speaking 99
Socialism Failing? 99
Annual Dues 100

Fourth Annual Michigan Postgraduate Clinical Institute.
Tentative Program 101
Annual Heart Day 105

University of Michigan Medical School Postgraduate Courses, 1950 105

Michigan's Department of Health 106

In Memoriam 110

Orientation Courses in Clinical Allergy 114

News Medical 116

Annual County Secretaries and Public Relations Conference 123

The Doctor's Library 124

You and Your Business 12

Cancer Comment 20

PR in Practice 23

H.R. 6000 (Extension of Social Security) 28

Michigan Medical Service 30

Michigan Health Council Elects J. S. De Tar President 32

Health Needs and Health Care in Michigan (Abstract)
Charles R. Hoffer, Duane L. Gibson, Charles P. Loomis, Paul A. Miller, Edgar Schuler and *John F. Thaden* 34

Political Medicine 40

Editorial Comment 44

THE JOURNAL
of the Michigan State Medical Society

VOLUME 49 JANUARY, 1950 NUMBER 1

Office of Publication
2642 University Avenue
Saint Paul 4, Minnesota

Editor
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

Secretary and Business Manager of THE JOURNAL
L. FERNALD FOSTER, M.D.
Thorne Bldg., 919 Washington Ave.
Bay City, Michigan

Executive Director
WM. J. BURNS, LL.B.
2020 Olds Tower, Lansing 8, Michigan

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscription should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 4, Minnesota, or 2020 Olds Tower, Lansing 8, Michigan. Telephone 57125.

Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 4, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $5.00; single copies, 50 cents. Additional postage; Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

PRINTED IN U.S.A.

OFFICERS OF THE SOCIETY

1949-50

President .....W. E. BARSTOW, M.D..... St. Louis
President-Elect .....C. E. UMPHREY, M.D..... Detroit
Secretary .....L. FERNALD FOSTER, M.D..... Bay City
Treasurer .....A. S. BRUNK, M.D..... Detroit
Speaker .....R. H. BAKER, M.D..... Pontiac
Vice Speaker .....J. E. LIVESAY, M.D..... Flint

THE COUNCIL

O. O. BECK, M.D., Chairman, Birmingham
R. J. HUBBELL, M.D., Vice Chairman, Kalamazoo
L. FERNALD FOSTER, M.D., Secretary, Bay City

	District		Term Expires
L. W. HULL, M.D.	1st	Detroit	1951
P. A. RILEY, M.D.	2nd	Jackson	1950
WILFRID HAUGHEY M.D.	3rd	Battle Creek	1950
R. J. HUBBELL, M.D.	4th	Kalamazoo	1951
J. D. MILLER, M.D.	5th	Grand Rapids	1951
R. C. POCHERT, M.D.	6th	Owosso	1951
H. B. ZEMMER, M.D.	7th	Lapeer	1952
L. C. HARVIE, M.D.	8th	Saginaw	1952
E. A. OAKES, M.D.	9th	Manistee	1952
F. H. DRUMMOND, M.D.	10th	Kawkawlin	1952
C. A. PAUKSTIS, M.D.	11th	Ludington	1953
A. H. MILLER, M.D.	12th	Gladstone	1953
W. S. JONES, M.D.	13th	Menominee	1953
J. S. DeTAR, M.D.	14th	Milan	1954
O. O. BECK, M.D.	15th	Birmingham	1950
E. A. OSIUS, M.D.	16th	Detroit	1950
W. B. HARM, M.D.	17th	Detroit	1953
WILLIAM BROMME, M.D.	18th	Detroit	1954

W. E. BARSTOW, M.D..... President ..... St. Louis
C. E. UMPHREY, M.D..... President-Elect ..... Detroit
R. H. BAKER, M.D..... Speaker ..... Pontiac
L. FERNALD FOSTER, M.D..... Secretary ..... Bay City
A. S. BRUNK, M.D..... Treasurer ..... Detroit
E. F. SLADEK, M.D..... Immediate Past President Traverse City

EXECUTIVE COMMITTEE OF THE COUNCIL

O. O. BECK, M.D.....Chairman
R. J. HUBBELL, M.D.....Vice Chairman
J. D. MILLER, M.D.....Chairman County Societies Committee
F. H. DRUMMOND, M.D.....Chairman Publication Committee
E. A. OSIUS, M.D.....Chairman Finance Committee
R. H. BAKER, M.D.....Speaker, House of Delegates
W. E. BARSTOW, M.D.....President
C. E. UMPHREY, M.D.....President-Elect
L. FERNALD FOSTER, M.D.....Secretary

SECTION OFFICERS

Medicine

G. C. Thosteson, M.D.....Detroit
Chairman
J. W. Hall, Jr., M.D.....Traverse City
Secretary

Surgery

H. K. Ransom, M.D.....Ann Arbor
Chairman
L. C. Carpenter, M.D.....Grand Rapids
Secretary

Gynecology and Obstetrics

H. H. Lampman, M.D.....Detroit
Chairman
P. E. Sutton, M.D..... Royal Oak
Secretary

Dermatology and Syphilology

R. H. Holmes, M.D.....Muskegon
Chairman
J. R. Delaney, M.D.....Detroit
Secretary

Radiology, Pathology, Anesthesiology

D. H. Kaump, M.D.....Detroit
Chairman (Path.)
J. E. Lofstrom, M.D.....Detroit
Vice Chairman (Rad.)
H. J. VanBelois, M.D.....Grand Rapids
Secretary (Anes.)

General Practice

J. F. Failing, M.D.....Grand Rapids
Chairman
E. H. Fenton, M.D.....Detroit
Secretary

Ophthalmology and Otolaryngology

J. E. Croushore, M.D.....Detroit
Chairman (Otolaryng.)
J. C. Gemeroy, M.D.....Detroit
Co-Chairman (Ophth.)
R. W. Teed, M.D.....Ann Arbor
Secretary (Otolaryng.)
F. B. Heckert, M.D.....Lansing
Co-Secretary (Ophth.)

Pediatrics

E. H. Watson, M.D.....Ann Arbor
Chairman
R. J. Mason, M.D.....Birmingham
Secretary

Urology

G. E. Chittenden, M.D.....Detroit
Chairman
Wm. Bromme, M.D.....Detroit
Secretary

Public Health and Preventive Medicine

O. D. Stryker, M.D.....Mt. Clemens
Chairman
O. K. Engelke, M.D.....Ann Arbor
Secretary

Nervous and Mental Diseases

P. C. Robertson, M.D.....Ionia
Chairman
R. A. Morter, M.D.....Kalamazoo
Secretary

DELEGATES TO A. M. A.

Delegates

W. D. Barrett, M.D., Detroit.....1950
W. H. Huron, M.D., Iron Mountain 1950
R. L. Novy, M.D., Detroit.....1950
L. G. Christian, M.D., Lansing.....1951
W. A. Hyland, M.D., Grand Rapids 1951

Alternates

R. A. Johnson, M.D., Detroit.....1950
R. H. Denham, M.D., Grand Rapids 1950
C. I. Owen, M.D., Detroit.....1950
H. H. Cummings, M.D., Ann Arbor 1951
E. C. Texter, M.D., Detroit.....1951

In the City of Bagdad lived Hakeem, the Wise One, and many people went to him for counsel, which he gave freely to all, asking nothing in return.

There came to him a young man, who had spent much but got little, and said: "Tell me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which cannot be bought or sold. Look for the Priceless Ingredient."

"But what is this Priceless Ingredient?" asked the young man.

Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the market-place is the Honor and Integrity of him who makes it. Consider his name before you buy."

MSMS Committee Personnel

Rheumatic Fever Control Committee

Frank Van Schoick, *Chairman*.....419 W. High Street, Jackson
P. C. Angove.....449 W. Ferry, Detroit
D. R. Boyd.....1735 Peck Street, Muskegon
N. E. Clarke.....2501 W. Grand Boulevard, Detroit
W. B. Cooksey.....62 W. Kirby Avenue, Detroit
Carleton Dean.....458 Hollister Building, Lansing
L. Fernald Foster.....919 Washington, Bay City
Thomas Francis, Jr.....School of Public Health, Ann Arbor
J. H. Fyvie.....Manistique
M. F. Osterlin.....201 State Bank Building, Traverse City
A. H. Price.....62 W. Kirby, Detroit
H. H. Riecker.....St. Joseph Mercy Hospital, Ann Arbor

Child Welfare Committee

L. P. Sonda, *Chairman*.....522 David Whitney Building, Detroit
R. J. Albi.....Boyne City
W. N. Braley.....12897 Woodward Avenue, Detroit
Moses Cooperstock.....Marquette
Carleton Dean.....458 Hollister Building, Lansing
A. E. Heustis.....Michigan Department of Health, Lansing
K. P. Hodges.....1116 Olds Tower Building, Lansing
R. M. Kempton.....333 S. Jefferson Avenue, Saginaw
R. J. Mason.....308 N. Woodward, Birmingham
A. L. Richardson.....651 Fisher Building, Detroit
R. S. Simpson.....1507 Central Tower, Battle Creek
J. N. P. Struthers.....310 S. Huron, Ypsilanti
J. E. Webber.....Medical Arts Building, Grand Rapids

Iodized Salt Committee

R. D. McClure, *Chairman*.....2799 W. Grand Boulevard, Detroit
H. A. Towsley, *Vice Chairman*.....1000 Berkshire, Ann Arbor
B. E. Brush.....2799 W. Grand Boulevard, Detroit
L. W. Gerstner.....420 John Street, Kalamazoo
D. E. Lichty.....417 First National Building, Ann Arbor
R. C. Moehlig.....965 Fisher Building, Detroit
G. P. Moore.....115 S. Mitchell, Cadillac
R. L. Waggoner.....St. Louis

Committee on Distribution of Medical Care

C. W. Colwell. *Chairman*.....706 Citizens Bank Building, Flint
R. H. Baker.....1110 Pontiac State Bank Building, Pontiac
H. F. Bibble.....1313 David Whitney Building, Detroit
B. J. Graham.....Alma
A. D. Hobbs.....St. Louis
E. B. Miller.....425 River Street, Manistee
J. R. Rodger.....Bellaire
R. A. Sokolov.....755 Fisher Building, Detroit

Maternal Health Committee

R. B. Kennedy, *Chairman*.....2108 David Broderick Tower, Detroit
W. H. Boughner.....Algonac
A. M. Campbell.....345 Cherry Street, S.E., Grand Rapids
A. L. Foley.....Rogers City
J. L. Gillard.....Michigan Theater Building, Muskegon
S. T. Lowe.....1009 Security Bank Building, Battle Creek
C. W. Newton.....415½ E. Liberty Street, Ann Arbor
H. A. Pearse.....852 Fisher Building, Detroit
J. R. Rodger.....Bellaire
J. N. Scher.....130 Cass Avenue, Mt. Clemens
L. C. Spademan.....1013 David Whitney Building, Detroit
P. E. Sutton.....629 Washington Square Building, Royal Oak
D. W. Thorup.....Fidelity Building, Benton Harbor
C. E. Toshach.....330 S. Jefferson, Saginaw
P. W. Willits.....Blodgett Medical Building, Grand Rapids

Mental Hygiene Committee

J. M. Dorsey, *Chairman*.....65 Moss Street, Highland Park
R. G. Brain.....509 First National Bank Building, Flint
F. P. Currier.....626 Medical Arts Building, Grand Rapids
W. W. Dickerson.....Caro State Hospital, Caro
T. J. Heldt.....Henry Ford Hospital, Detroit
H. C. Hill.....Howell
M. H. Hoffman.....1311 David Whitney Building, Detroit
C. G. Jennings.....7815 Jefferson, Detroit
Ralph Kernkamp.....1229 David Whitney Building, Detroit
H. A. Luce.....629 David Whitney Building, Detroit
F. O. Meister.....1007 Security Bank Building, Battle Creek
R. A. Morter.....Kalamazoo State Hospital, Box A, Kalamazoo
R. W. Waggoner.....1313 E. Ann Street, Ann Arbor
H. B. Zemmer.....Clay Street, Lapeer

Beaumont Memorial Committee

F. A. Coller, *Chairman*.....1313 E. Ann Street, Ann Arbor
J. K. Heckert.....1105 Bank of Lansing Building, Lansing
F. C. Kidner.....1337 David Whitney Building, Detroit
A. W. Lescohier.....663 University Place, Detroit
F. C. Mayne.....Cheboygan

Committee on Geriatrics

W. B. Cooksey, *Chairman*.....62 W. Kirby, Detroit
H. H. Riecker, *Vice Chairman*, St. Joseph Mercy Hosp., Ann Arbor
F. W. Baske.....1217 Mott Foundation Building, Flint
M. G. Becker.....Edmore
J. R. Brink.....308 Metz Building, Grand Rapids
B. B. Bushong.....116 Cass Street, Traverse City
C. D. Camp.....304 S. State Street, Ann Arbor
M. S. Chambers.....839 Mott Foundation Building, Flint
R. C. Dixon.....Pigeon
J. M. Dorsey.....65 Moss, Highland Park
D. C. Ensign.....2799 W. Grand Boulevard, Detroit
P. C. Gittins.....732 Maccabees Building, Detroit
F. J. Gugino.....Reese
M. A. Hoffs.....Lake Odessa
L. E. Irvine.....422 3rd Street, Iron River
R. A. Johnson.....7815 E. Jefferson, Detroit
F. D. Johnston.....1313 E. Ann Street, Ann Arbor
P. B. Kilmer.....Reed City
P. L. Ledwidge.....1838 David Whitney Building, Detroit
W. M. LeFevre.....289 W. Western Avenue, Muskegon
J. D. Littig.....1210 American National Bank Building, Kalamazoo
Mark Marshall.....St. Joseph Mercy Hospital, Ann Arbor
J. M. Murphy.....710 David Whitney Building, Detroit
J. G. Ruth.....190 Michigan, Benton Harbor
W. A. Schaefer.....302 First National Bank Building, Port Huron
F. C. Swartz.....108 E. St. Joseph, Lansing
G. C. Thosteson.....1139 David Whitney Building, Detroit
L. E. Verity.....1414 Security Bank Building, Battle Creek
W. J. Wilson, Jr.....749 David Whitney Building, Detroit

Sub-Committee to Study Problems of Caring for the Aged

H. H. Riecker, *Chairman*.....Ann Arbor
C. D. Camp.....Ann Arbor
Mark Marshall.....Ann Arbor
M. G. Becker.....Edmore

Sub-Committee on Diabetes Control

W. M. LeFevre, *Chairman*.....Muskegon
Sidney Adler.....Detroit
F. W. Baske.....Flint
J. M. Bauer.....Ann Arbor
R. A. Johnson.....Detroit
J. D. Littig.....Kalamazoo
W. L. Lowrie, Jr.....Detroit
R. L. Schaefer.....Detroit
G. C. Thosteson.....Detroit
S. C. Wiersma.....Muskegon

Committee on Scientific Work

L. Fernald Foster, *Chairman*.....919 Washington, Bay City
(Plus Section Officers)

Cancer Control Committee

N. F. Miller, M.D., *Chairman*.....1313 E. Ann Street, Ann Arbor
H. M. Bishop.....515 S. Jefferson, Saginaw
D. C. Burns.....314½ Howard Street, Petoskey
L. A. Campbell.....405 Peoples Building, Saginaw
E. I. Carr.....300 W. Ottawa, Lansing
M. A. Darling.....673 Fisher Building, Detroit
B. J. Graham.....Alma
A. E. Heustis.....Michigan Department of Health, Lansing
L. E. Holly.....876 N. Second Street, Muskegon
R. H. Holmes.....316 Hackley Union Building, Muskegon
A. A. Humphrey.....151 Ann Avenue, Battle Creek
W. H. Huron.....105 East A Street, Iron Mountain
W. A. Hyland.....Metz Building, Grand Rapids
C. H. Keene.....2120 Wellingford Road, Ann Arbor
D. J. Leithauser.....14727 E. Jefferson, Detroit
H. F. Mattson.....Broad Street, Hillsdale
A. B. McGraw.....2799 W. Grand Boulevard, Detroit
H. L. Miller.....617 Washington Square Building, Royal Oak
H. M. Nelson.....1067 Fisher Building, Detroit
C. A. Payne.....Blodgett Memorial Building, Grand Rapids
H. M. Pollard.....1313 E. Ann Street, Ann Arbor
H. W. Porter.....505 Wildwood, Jackson
H. R. Prentice.....458 W. South Street, Kalamazoo
H. L. Sigler.....Howell
H. L. Smith.....16401 Grand River Avenue, Detroit
F. A. Coller, *Advisor*.....1313 E. Ann Street, Ann Arbor
F. L. Rector, *Secretary*.....1313 E. Ann Street, Ann Arbor

Scientific Radio Committee

J. M. Sheldon, *Chairman*.....
Dept. Postgraduate Medicine, U. of M., Ann Arbor
R. E. Boucher.....617 Washington Square Building, Royal Oak
T. T. Callaghan.....312 Professional Building, Detroit
J. H. McMillin.....130 Maple Boulevard, Monroe
Kenneth W. Toothaker.....320 Townsend, Lansing
H. M. Pollard, Advisor.....1313 E. Ann Street, Ann Arbor
G. H. Scott, Ph.D.....Dean, Wayne Univ. College of Med., Detroit

(Continued on Page 8)

MSMS Committee Personnel

(Continued from Page 6)

Committee on Tuberculosis Control

Cameron Haight, *Chairman*.....2112 Vinewood Boulevard, Ann Arbor
J. L. Egle.....Northern Michigan TB Sanatorium, Gaylord
R. J. Hanna.....1204 Fourth Street, Jackson
A. E. Heustis.....Michigan Department of Health, Lansing
R. C. Hildreth.....458 W. South, Kalamazoo
R. H. Holmes.....316 Hackley Bank Building, Muskegon
P. J. Howard.....2799 W. Grand Boulevard, Detroit
W. L. Howard.....Maybury Sanatorium, Northville
H. G. Huntington.....Howell
C. E. Lemmon.....1337 David Whitney Building, Detroit
V. C. Johnson.....3825 Brush Street, Detroit
G. T. McKean.....1515 David Whitney Building, Detroit
E. J. O'Brien.....307 David Whitney Building, Detroit
R. A. Rasmussen.....Blodgett Hospital, Grand Rapids
C. J. Stringer.....Ingham County Sanatorium, Lansing
G. C. Tornberg.....124 E. Case Street, Cadillac
J. W. Towey.....Powers
B. R. Van Zwalenburg.....Metz Building, Grand Rapids
O. R. Yoder.....Ypsilanti State Hospital, Ypsilanti
O. O. Beck *(Advisor re Prison Health)*....274 W. Maple, Birmingham
P. A. Riley *(Advisor re Prison Health)*.....500 S. Jackson, Jackson

Committee on Venereal Disease Control

L. W. Shaffer, *Chairman*, 724 Hawthorne Rd., Grosse Pointe Woods
R. S. Breakey, *Vice Chairman*....1211 Bank of Lansing Bldg., Lansing
R. C. Crowell.....16 Peoples State Bank Building, St. Joseph
A. C. Curtis.....1313 E. Ann Street, Ann Arbor
E. A. Hand.....211 Bearinger Building, Saginaw
Ruth Herrick.....303 Medical Arts Building, Grand Rapids
R. H. Holmes.....888 First Street, Muskegon
H. L. Keim.....1110 David Broderick Tower, Detroit
Frank Stiles.....2012 Olds Tower Bldg., Lansing
D. E. Siler.....1811 N. Michigan Avenue, Saginaw
O. D. Stryker.....Macomb County Health Dept., Mt. Clemens

Joint Committee on Infectious Diarrhea

G. D. Cummings, *Chairman*.....Michigan Dept. of Health, Lansing
Bernard Bernbaum.....922 Maccabees Building, Detroit
W. L. Harrigan.....Mt. Pleasant
J. H. Lewis.....2956 Biddle, Wyandotte
S. W. Miller.....Alma
R. K. Whiteley.....541 David Whitney Building, Detroit

Public Relations Committee

L. W. Hull, *Chairman*.....1701 David Whitney Building, Detroit
C. L. Candler, *Vice Chairman*....2006 David Broderick Tower, Detroit
Hugo Aach.....1318 American National Bank, Kalamazoo
G. T. Aitken.....1029 San Jose Drive, Grand Rapids
J. F. Beer.....S. Riverside Drive, St. Clair
E. W. Blanchard.....Deckerville
A. F. Bliesmer.....2208 Lakeview, St. Joseph
H. R. Bodine.....1506 Security Bank Building, Battle Creek
A. S. Brunk.....58 Martin Place, Detroit
C. G. Clippert.....Grayling
T. S. Conover.....420 Genesee Bank Building, Flint
L. Fernald Foster.....919 Washington, Bay City
W. G. Gamble.....Mercy Hospital, Bay City
L. J. Gravelle.....1101 David Whitney Bldg., Detroit
A. B. Gwinn.....Pennock Hospital, Hastings
S. W. Hartwell.....452 W. Western Averne, Muskegon
L. T. Henderson.....13038 E. Jefferson, Detroit
W. J. Herrington.....Bad Axe
F. P. Husted.....1100 Fifth Avenue, Bay City
Kenneth Johnson.....1116 Olds Tower Building, Lansing
F. J. Kemp.....1115 Peoples State Bank, Pontiac
R. C. Kingswood.....90 E. Warren, Detroit
J. J. Lightbody.....195 Piper Blvd., Detroit
J. E. Livesay.....619 Mott Foundation Building, Flint
J. J. McCann.....Ionia
O. B. McGillicuddy.....1816 Olds Tower Building, Lansing
H. J. Meier.....87 N. Pearl, Coldwater
E. B. Miller.....425 River, Manistee
B. T. Montgomery.....Sault Ste. Marie
E. S. Oldham.....Breckenridge
H. F. Osterhagen.....W. Bay Shore Drive, Traverse City
C. A. Payne.....Blodgett Memorial Hospital, Grand Rapids
L. A. Pratt.....3919 John R., Detroit
W. Z. Rundles.....620 Maxine Avenue, Flint
R. F. Salot.....Mt. Clemens
G. B. Saltonstall.....Charlevoix
A. E. Schiller.....2008 David Broderick Tower, Detroit
D. R. Smith.....105 East "A" Street, Iron Mountain
A. H. Steele.....Paw Paw
R. W. Teed.....410 Highland Road, Ann Arbor
Arch Walls.....12065 Wyoming, Detroit
C. L. Weston.....Owosso
A. H. Whittaker.....1427 E. Jefferson, Detroit
T. P. Wickliffe.....Calumet
G. B. Wickstrom.....Madigan Building, Munising
D. B. Wiley.....Utica

Sub-Committees of Public Relations Committee

Committee on Newspapers

C. L. Weston, *Chairman*.....Owosso
G. T. Aitken.....1029 San Jose Drive, Grand Rapids
J. J. Lightbody.....195 Piper Blvd., Detroit
H. J. Meier.....87 N. Pearl, Coldwater

Committee on Cinema

Arch Walls, *Chairman*.....12065 Wyoming, Detroit
R. F. Salot.....Mt. Clemens
A. E. Schiller.....2008 David Broderick Tower, Detroit

Committee on Public Relations Publications

Kenneth Johnson, *Chairman*.....1116 Olds Tower Building, Lansing
A. F. Bliesmer.....2208 Lakeview, St. Joseph
L. Fernald Foster.....919 Washington, Bay City
L. T. Henderson.....13038 E. Jefferson, Detroit
J. E. Livesay.....619 Mott Foundation Bldg., Flint

Committee on Education Programs in Schools and Universities

D. B. Wiley, *Chairman*.....Utica
J. S. Lambie.....Fisher Body Co., Pontiac
J. J. McCann.....Ionia
E. B. Miller.....425 River, Manistee
A. H. Steele.....Paw Paw

Committee on Radio

C. A. Payne, *Chairman*....Blodgett Memorial Hospital, Grand Rapids
C. L. Candler.....2006 David Broderick Tower, Detroit
W. G. Gamble, Jr.....Mercy Hospital, Bay City
W. J. Herrington.....Bad Axe
R. W. Teed.....215 S. Main, Ann Arbor

Committee on Mediation

W. Z. Rundles, *Chairman*.....304 First National Building, Flint
A. F. Bliesmer.....505 Pleasant Street, St. Joseph
B. R. Corbus.....Metz Building, Grand Rapids
V. H. Dumond.....230 Shearer Building, Bay City
F. W. Hyde, Sr.....6104 W. Vernor Hwy., Detroit
E. T. Morden.....109 E. Maumee Street, Adrian
R. W. Teed.....215 S. Main Street, Ann Arbor
Arch Walls.....12065 Wyoming Ave., Detroit
H. B. Zemmer.....Clay Street, Lapeer

Legislative Committee

L. A. Drolett, *Chairman*.....901 Prudden Building, Lansing
E. R. Addison.....Crystal Falls
O. O. Beck.....274 W. Maple, Birmingham
W. A. Chipman.....14920 Grand River, Detroit
G. V. Conover.....420 Genesee Bank Building, Flint
E. F. Ducey.....St. Mary's Hospital, Grand Rapids
D. L. Finch.....Security National Bank Bldg., Battle Creek
C. B. Gardner.....320 Townsend, Lansing
T. J. Kane.....179 S. Strong Avenue, Muskegon
E. D. King.....5455 W. Vernor Highway, Detroit
O. B. McGillicuddy.....1816 Olds Tower Building, Lansing
W. F. Mertaugh.....Sault Ste. Marie
H. L. Morris.....1069 Fisher Building, Detroit
W. E. Nesbitt.....31 Second Avenue, Alpena
C. L. A. Oden.....804 Hackley Union Bank Bldg., Muskegon
C. W. Reuter.....Allen Clinic, Bay City
E. W. Schnoor.....216 Medical Arts Building, Grand Rapids
G. W. Slagle.....1206 Security Tower, Battle Creek
J. G. Slevin.....1514 David Broderick Tower, Detroit
R. A. Springer.....Centerville
Charles Ten Houten.....Paw Paw
F. L. Troost.....Holt
C. E. Umphrey.....13331 Livernois, Detroit
R. V. Walker.....1255 David Whitney Bldg., Detroit

Postgraduate Medical Education Committee

H. H. Cummings, *Chairman* (1952).....
Dept. of Postgraduate Medicine, U. of M., Ann Arbor
E. I. Carr, *Vice Chairman* (1952).....300 W. Ottawa, Lansing
B. R. Corbus (1950).....Metz Building, Grand Rapids
G. J. Curry (1951).....401 Genesee Bank Building, Flint
A. C. Furstenberg (1951).....1313 E. Ann Street, Ann Arbor
L. J. Gariepy (1952).....16401 Grand River, Detroit
John Heidenreich (1950).....Daggett
A. C. LaBine (1952).....Houghton
P. A. Riley (1951).....500 S. Jackson, Jackson
J. M. Robb (1950).....641 David Whitney Building, Detroit
J. M. Sheldon (1950).....1313 E. Ann Street, Ann Arbor
W. J. Smith (1950).....Cadillac
E. D. Spalding (1950).....10 Peterboro, Detroit
F. A. Weiser (1951).....1533 David Whitney Building, Detroit
G. H. Scott, Ph.D., *Acting Dean*.....Wayne U. of Med. Detroit

(Concluded on Page 10)

MSMS Committee Personnel

(Continued from Page 8)

Preventive Medicine Committee

W. S. Reveno, *Chairman*.....951 Fisher Building, Detroit
Max R. Burnell.....3044 W. Grand Blvd., Detroit
W. B. Cooksey.....62 W. Kirby, Detroit
G. D. Cummings.....Michigan Dept. of Health, Lansing
H. H. Cummings.....Dept. Postgraduate Med., U. of M., Ann Arbor
J. M. Dorsey.....65 Moss, Highland Park
Cameron Haight.....2112 Vinewood, Ann Arbor
A. E. Heustis.....Michigan Dept. of Health, Lansing
R. B. Kennedy.....2108 David Broderick Tower, Detroit
R. D. McClure.....2799 W. Grand Blvd., Detroit
N. F. Miller.....1313 E. Ann Street, Ann Arbor
L. W. Shaffer.....3852 Bishop Road, Detroit
J. M. Sheldon.....Dept. Postgraduate Med., U. of M., Ann Arbor
L. P. Sonda.....552 David Whitney Bldg., Detroit
Frank Van Schoick.....419 W. High, Jackson

Advisory Committee to National Foundation for Infantile Paralysis

M. F. Osterlin, *Chairman*.....Traverse City
O. O. Beck.....274 W. Maple, Birmingham
F. E. Curtis.....10 Peterboro, Detroit
H. B. Fenech.....324 Professional Bldg., Detroit
N. R. Moore.....Shearer Building, Bay City
H. H. Stryker.....Borgess Hospital, Suite 583, Kalamazoo

Ethics Committee

R. S. Morrish, *Chairman* (1950).....1715 Crescent Drive, Flint
D. C. Eisele (1952).....Ironwood
W. L. Harrigan (1953).....Mt. Pleasant
L. C. Harvie (1950).....405 Wiechman Building, Saginaw
H. B. Hoffman (1952).....119½ Ludington, Ludington
G. B. Hoops (1953).....754 Fisher Bldg., Detroit
L. J. Morand (1951).....641 David Whitney Bldg., Detroit
W. E. Nesbitt (1951).....31 Second Avenue, Alpena

Industrial Health Committee

Max R. Burnell, *Chairman*.....3044 W. Grand Blvd, Detroit
N. H. Amos.....1704 Central Tower, Battle Creek
A. L. Brooks.....Med. Dir., Fisher Body Division, Flint
W. P. Chester.....5057 Woodward, Detroit
Henry Cook.....326 Genesee Bank Bldg., Flint
W. A. Dawson.....25951 Avondale Rd., Inkster
H. H. Gay.....Dow Chemical Co., Midland
Raymond Hussey.....1547 Penobscot Bldg., Detroit
O. J. Johnson.....207 N. Walnut, Bay City
J. S. Lambi.....Fisher Body, Pontiac
V. S. Laurin.....804 Hackley Union Bank Bldg., Muskegon
J. M. Lynch.....Michigan Dept. of Health, Lansing
R. D. Mudd.....Chevrolet Iron Foundry, Saginaw
N. W. Scholle.....Anderson Building, Muskegon Heights
H. T. Sethney.....Electric Square Building, Menominee
M. W. Shellman.....Metz Building, Grand Rapids
A. H. Whittaker.....1427 E. Jefferson, Detroit
J. L. Zemens.....1761 Broadstone, Grosse Pointe Woods
C. D. Selby, *Advisory*.....Univ. of Michigan School of P. H., A. A.

Advisory Committee to Women's Auxiliary

F. D. Johnson, *Chairman*.....202 Paterson Building, Flint
C. J. Barone.....51 Eason, Highland Park
C. W. Oakes.....Harbor Beach
C. A. Payne.....Blodgett Memorial Hospital, Grand Rapids
Sherwood Russell.....104 N. Oakland Street, St. Johns
R. W. Ullrich.....91 Cass Avenue, Mt. Clemens

Committee of Six to Study Basic Science Act and Medical Practice Act

P. L. Ledwidge, *Chairman*.....1838 David Whitney Bldg., Detroit
C. B. Gardner.....320 Townsend, Lansing
L. J. Gariepy.....16401 Grand River Avenue, Detroit
D. A. Kerr, D.D.S.....1306 Iroquois, Ann Arbor
O. E. Madison, Ph.D.....Wayne University, Detroit
E. F. Sladek.....123 E. Front St., Traverse City

You and Your Business

AMA VOTES $25 DUES FOR 1950

The House of Delegates of the American Medical Association, at the Interim Session in Washington, D. C., on December 8, 1949, adopted $25.00 dues for active members of the American Medical Association for the year 1950. In a telegram of notification, George F. Lull, M.D., AMA Secretary and General Manager, states: "Said dues will be collected by state or county societies in accordance with local custom for collecting your own dues and will be transmitted to Secretary of the American Medical Association."

Up to this year, the AMA has never had any annual dues. A year ago it called on its members for a voluntary assessment of $25.00 to finance an educational program to acquaint the public with the dangers of compulsory health insurance or socialized medicine.

This action of the AMA House of Delegates was approved by the Executive Committee of The Council of the Michigan State Medical Society on December 21, 1949.

HOSPITALIZATION OF VETERANS RISING

Latest monthly report by Veterans Administration shows that its hospital load stood at 109,378 on October 31, compared with 108,261 on September 30. Continuing increases, small but steady, are anticipated. Nearly 90 per cent of the patients are in Veterans Hospitals, the remainder in private and other federal institutions. At the end of October, 19,717 were awaiting admission, only fifty of which were for disabilities adjudicated as service-connected.—Washington Report on Medical Sciences, December 5, 1949.

INDUSTRIAL HEALTH CONFERENCE

Max R. Burnell, M.D., and J. L. Zemens, M.D., both of Detroit, representing, respectively, the Michigan State Medical Society and the Michigan Association of Industrial Physicians and Surgeons, are working on arrangements and program for the Industrial Health Conference scheduled for March 29, 1950, in Ann Arbor.

Other agencies co-sponsoring the industrial health day are the School of Public Health of the University of Michigan, the Medical School of the University of Michigan, Wayne University College of Medicine, and the Michigan State Department of Health.

M. R. Burnell, M.D.

J. L. Zemens, M.D.

Dr. Burnell, Chairman of the MSMS Industrial Health Committee and Dr. Zemens, President of the Michigan Association of Industrial Physicians and Surgeons, presented plans for the industrial health day at a meeting in Detroit on November 30. A tentative program featuring nationally known lecturers in the field of industrial medicine and surgery—and including audience participation—was agreed upon.

The joint statement of Drs. Burnell and Zemens follows:

"The Industrial Health Conference of March 29, will offer a continuation course in this specialty that will interest not alone surgeons and medical men in industry but all medical practitioners in the State of Michigan, in neighboring states, and in the Province of Ontario. The program is designed to be of especial value to the doctor of medicine who does not profess to limit his practice to industrial medicine and surgery but whose practice demands a knowledge of modern industrial medicine and surgery.

"Every member of the Michigan State Medical Society will be invited to attend the Industrial Health Day in March; those who take advantage of this opportunity will gain much of useful value in their everyday practice."

President Whittaker to Be Honored

The scientific program will be followed by a prepandial hour and a dinner arranged in honor of the President of the American Association of In-

(Continued on Page 14)

Physicians' choice

in a wide variety of allergic disorders

TRIMETON

Schering

TRIMETON

SCHERING

INDUSTRIAL HEALTH CONFERENCE

(Continued from Page 12)

dustrial Physicians and Surgeons, Alfred H. Whittaker, M.D., Detroit.

The program of March 29 will be mailed to every member of the Michigan State Medical Society in February.

SOCIALIST ENGLAND

One may not buy a penny's worth of candy without a sweets coupon from a ration book. Meat, fats, sugar, coal, and chicken feed are all rationed. The commonest things are unobtainable. Britain is a land of slot machines without chocolate, bread without butter, public lavatories without soap, tables without napkins, homes without central heating, and meals without meat. It is a land where the average householder has one good dinner a week—on Sunday when the family, pooling coupons, gets its joint. On Monday leftovers are consumed. The next five dinners ring the changes on fish, "offal" (liver, kidneys, tripe), and sausage. Those who can afford it, eat out, but there's a hitch to that line of escape.

In 1946 the Socialist Government passed a law forbidding public eating places to serve a meal costing more than 5 shillings (70 cents). A dinner at that price is a sad affair. According to Socialist theory everyone is supposed to be equal.

Housewives must sign up with dealers for milk, meats, fats, cheese, bacon, and sugar. A woman cannot shop around or go to another store if she does not like what she finds in one store. She is compelled to file the names of her food dealers with the Government. One's destiny is thus tied to particular dealers. This has advantages. Your dealer looks after you, in a black market sort of way. For instance, suppose your family's coupons would entitle you to a 4-lb. joint on Saturday. If the coast is clear and there are no government spies around, the butcher may cut off a 6-lb. roast. He gives you the high sign. "It's 6-lbs.," he whispers. You say: "Fine!" He looks around. "Here, take it quick and get out!" he warns.—Marjorie Sharon's Report of a trip to Socialist England, December 15, 1949.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of November 17, 1949

- Monthly financial reports, including statements on the Public Education Account and the Public Education Reserve Account, were presented, studied, and approved.
- State Health Commissioner A. E. Heustis, M.D., reported on the need for increased financial aid to local health departments and advised that a duplicate of S.B.134, as introduced into the 1949 Michigan Legislature, would be re-introduced in next year's Legislature; that one local health department (Cass County) had been lost during the past year and that Berrien, Jackson and Marquette Counties do not have local health departments. The matter was referred to the Councilors in the Districts concerned.
- Committee reports were presented by the Mental Hygiene Committee (two meetings); Committee on Scientific Work; Committee on Rural Medical Care; Advisory Committee on Rural Health Survey; Maternal Health Committee; Rheumatic Fever Control Committee; Cancer Control Committee; Public Relations Committee; and the Special Committee on Education.
- Drs. A. D. Allen, Bay City, and John R. Rodger, Bellaire, members of the Advisory Committee to the Michigan Office of Hospital Survey and Construction, gave a progress report of activities in Michigan under the Hill-Burton Act; the goal of this legislation is to have 4½ beds per thousand population in each district. The Michigan Health Plan for Hospital Survey and Construction, after full study, was referred back to the Rural Medical Care Committee for re-study and further recommendation.
- The very successful Third Annual Michigan Rural Health Conference, held October 28-29, 1949, in Grand Rapids, was reported by R. J. Hubbell, M.D., of Kalamazoo, Chairman of the MSMS Rural Health Committee, who also gave a résumé on the five resolutions passed at the Conference. A letter of

(Continued on Page 16)

worth consideration . . .

YOUR FUTURE WITH THE ARMY OR THE AIR FORCE MEDICAL CORPS

Advanced medical and surgical practice with latest and most modern equipment and techniques.

Applied or pure research in many areas of medical science. Facilities of military and civilian medical centers—use of civilian consultant program.

Charted advancement in your selected career field with less administrative burden, more opportunity to practice.

Important personal rewards through extra professional pay on top of base pay, food and quarters allowances, other extras. Free retirement at comparatively early age.

Increased professional standing through contribution to a progressive, highly-specialized field of modern medicine. The military doctor-and-officer enjoys a two-fold responsibility and authority . . . contributes doubly to national welfare!

U. S. ARMY
MEDICAL DEPARTMENT
U. S. AIR FORCE
MEDICAL SERVICE

Your skills are vitally important to the national security effort. Write the Surgeon General, U. S. Army, or the Surgeon General, U. S. Air Force, Washington 25, D. C., for full details about Reserve Commissions and active duty!

HIGHLIGHTS OF THE EXECUTIVE COMMITTEE

(Continued from Page 14)

thanks was directed to be sent to the Michigan Foundation for Medical and Health Education, Inc., financial sponsor of the Conference, as well as to the Michigan Health Council for handling of all details of the meeting.

- President W. E. Barstow, M.D., reported that Dr. J. L. Christianson of the University of Minnesota had accepted his invitation to deliver the Biddle Lecture at the MSMS Annual Session, on September 20, 1950, in Detroit.
- The President-Elect, C. E. Umphrey, M.D., Detroit, recommended that formal thanks be sent to the *Detroit Times* and to writer Jack Pickering for the editorial of October 10, 1949, entitled "Sneaky Washington Effort To Bulldoze Michigan Doctors." This was approved by the Executive Committee of The Council.
- Chairmen of Rheumatic Fever Control Centers, as appointed by local county medical societies, were reported as follows: Harold Kessler, M.D., Alpena County; L. Fernald Foster, M.D., Bay County; Frank Van Schoick, M.D., Jackson County; H. S. Heersma, M.D., Kalamazoo County; Jerome E. Webber, M.D., Kent County; Norman E. Clarke, M.D., Wayne County; DeVere R. Boyd, M.D., Muskegon County; David P. Gage, M.D., Saginaw County; Donald S. Smith, M.D., Oakland County.
- The Michigan Chapter, Arthritis and Rheumatism Foundation, granted $4,500 and the Michigan Society for Crippled Children and Adults, Inc., granted $6,000 to the Michigan Rheumatic Fever Control Program of the Michigan State Medical Society, as reported by Secretary L. Fernald Foster, M.D.
- The monthly report of the Medical Co-ordinator of the Rheumatic Fever Control Program was read and approved.
- Program of the annual County Secretaries-Public Relations Conference to be held at the Book-Cadillac Hotel, Detroit, on Sunday, January 22, 1950, was presented by the Secretary and approved.
- R. J. Hubbell, M.D., Kalamazoo, was appointed as MSMS representative to the American Medical Association's Rural Health Conference to be held in Kansas City, February, 1950.
- Carleton Dean, M.D., Lansing, was appointed to represent the Michigan State Medical Society on the Advisory Committee of the Michigan Department of Public Instruction re qualifications for local persons in diagnostic service for mentally handicapped children.
- Proposed letter to be sent by the MSMS Cancer Control Committee to the chairmen of each cancer control committee in the State of Michigan (on the county or city level) was read and approved by the Executive Committee of The Council.
- The monthly reports of the President, President-Elect, Editor, and General Counsel were approved.
- Public Relations Counsel H. W. Brenneman reported that the organization of legal counsels of various state medical societies, instigated by the Michigan State Medical Society, had been carried out by the American Medical Association; the first meeting of these legal counsels will be held in Washington, D. C., during the AMA Interim Session.
- The holding of periodic conferences with the press by MSMS Officers or their designated alternates was authorized by the Executive Committee of The Council.
- A proposed program concerning "sex deviates" was presented to and discussed by the Executive Committee of The Council which referred it to a special committee, to be appointed by the Council Chairman, representative of the MSMS Mental Hygiene Committee, of the Legislative Committee, with Mr. Brenneman to serve as public relations advisor.

RESIDENCY TRAINING REQUIREMENTS

The American Board of Obstetrics and Gynecology has not made nor is it contemplating any changes in its residency training requirements, despite rumors of an increase in training years. Eligibility requirements remain the same, namely, three years of acceptable formal training, followed by at least two years of post-training practice in the specialty.

Hospitals are inspected and approved for training jointly by the Council on Medical Education and Hospitals of the American Medical Association and this Board. Approvals are granted for training periods of one, two and three years depending on the available facilities and the findings of the survey inspections.

This Board has no objection to residency services being arranged by hospitals for periods longer than three years, unless this dilutes the candidates's clinical training opportunities too much during the first three years. However, the Board does not accept a fourth year, or

(Continued on Page 18)

RESIDENCY TRAINING REQUIREMENTS

(Continued from Page 16)

more, of residency training as a substitute for any part of the required two years of post-training practice.

The importance of post-training practice in the specialty is emphasized as an opportunity for maturing of the candidate and for colleague appraisal of a man's ability when working on his own responsibility in his chosen community. The only exception to this ruling is in the case of men advancing from their training into full-time teaching positions. These men then must complete at least two years in such positions.

Copies of the Bulletin of this Board, outlining the above requirements in more detail, are available to hospital administrators or to candidates, upon application.

PAUL TITUS, M.D., *Secretary,*
American Board of Obstetrics and Gynecology
1015 Highland Building,
Pittsburgh 6, Pennsylvania.

RESEARCH FELLOWSHIPS

Ten research fellowships will be awarded for one calendar year in the fields of medicine, dentistry, and pharmacy by the University of Illinois Graduate College in Chicago.

The fellowships carry stipends of $1,800 per year for medical and dental graduates and $1,200 for pharmacy graduates, with exemption from tuition fees for all appointees. In unusal cases, a $2,400 stipend may be awarded to those holding a Doctor's degree. Registration in the Graduate College for full time credit toward M.S. or Ph.D. degrees is required.

Fellowships provide opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are primarily for graduates who are in the early stages of their preparation for a teaching and research career in medical and dental problems, although time credit toward specialty board requirements in basic sciences is recognized.

Fellows may be reappointed in competition with new applicants.

Candidates for fellowships must have completed a minimum training in any one of the following ways or the equivalent thereof:

1. Bachelor's and M.D. degrees.
2. Bachelor's and D.D.S. degrees.
3. Bachelor's degree in Pharmacy and M.S. degree.

Appointments will be announced March 1, for fellowships beginning July 1, or September 1, 1950.

Formal application blanks may be secured from the Assistant Dean, The Graduate College, University of Illinois, 808 South Wood Street, Chicago 12, Illinois.

TAXES

The following tabulation shows graphically the amount of tax paid to the Federal Government, the amount returned to the state, and the approximate percentage returned:

State	Tax Paid to Federal Government	Amount of Tax Returned to States	Percentage Returned
Alabama	$ 276,943,828	$133,399,689	48 %
Arkansas	121,751,193	96,959,563	79.5%
California	3,103,679,127	393,448,101	12 %
Colorado	291,848,648	77,986,957	27 %
Connecticut	664,939,280	57,223,656	8.5%
Georgia	439,033,999	133,655,573	30 %
Illinois	3,785,815,370	278,727,363	7.5%
Michigan	2,252,280,551	193,467,807	9 %
New York	7,975,513,716	432,941,740	5.5%
Ohio	2,665,707,099	236,982,646	9 %
Pennsylvania	3,222,789,298	359,300,954	11 %
Texas	1,285,123,045	352,855,457	27.5%

The grand total collected was over forty Billions of Dollars, and about five and a half billions were returned to the states. About 14 per cent came back to the states.

GOVERNMENT COSTS

The Bureau of Government Research has issued a report of government expenses covering the ten top states for 1948. These are the figures for cost per person. Michigan ranks second.

Nevada	$113.92	Arizona	$92.76
Michigan	108.47	Utah	89.45
New Mexico	105.11	Wyoming	83.47
Washington	101.45	Connecticut	82.17
Colorado	100.09	Florida	81.64

In 1946, Michigan ranked tenth, with a cost of $52.46; and in 1947 she was sixth, with a cost of $71.53.

The Michigan Heart Association offers speakers on heart disease topics as part of its educational program, during January, February, March, 1950, through the channels of the Department of Postgraduate Medicine of the University of Michigan. The following speakers and their subjects are available. Inquiries should be addressed to Leon DeVel, M.D., Secretary, Michigan Heart Association, 739 Plymouth N. E., Grand Rapids: Cameron Haight, M.D., or Herber E. Sloan, Jr., M.D., "Surgical Treatment of Congenital Heart Disease"; J. Marion Bryant, M.D., "Management of Cardiac Arrhythmias, "Congestive Cardiac Failure" "The Newer Digitalis Preparations," "Sodium Restrictions in Hypertension"; Franklin D. Johnston, M.D., "A Common Sense Approach to Cardiac Problems"; Paul S. Barker, M.D., "Some Aspects of Coronary Artery Disease"; Sibley W. Hoobler, M.D., "Hypertension," "Congestive Cardiac Failure," "Cardiac Catheterization," "Diagnosis of Congenital Heart Disease"; Earl Irvin, M.D., and John Bielawski, M.D., "Industrial Cardiology"; and Manes Hecht, M.D., and Leon DeVel, M.D., "Rheumatic Fever and Rheumatic Heart Disease."

* * *

The Academy of Forensic Sciences held its first meeting at Northwestern University School of Law, with headquarters at the Sheraton Hotel, Chicago, on January 26-27-28. LeMoyne Snyder, M.D., J.D., Lansing, was one of the organizers of the Academy.

SNOOZER PETE
is a Breakfast Cheat

Skip the morning repast? Not Pete. If he snoozes until 8:02, he can still make the 8:24 by a flying leap—with a few minutes at the other end for gulped coffee and a cigarette. Scanty breakfast? He'll make it up at lunch—if he has time.

Pete doesn't think he's a meal-cheater. Neither does the food faddist, the worrier, the reducing "expert" nor any of their kin likewise committed to dietary sin. Thus do they become prey to all the associated evils of subclinical vitamin deficiency.

When you examine the habit patterns of these patients, it's obvious that overnight dietary reform won't come easy. So isn't it wise to make use of the aid provided by vitamin supplementation?

Wise also to specify ABBOTT. You know there's a dependable ABBOTT vitamin product to serve nearly every vitamin need—for supplementary or therapeutic levels of dosage, for oral or parenteral administration. Your pharmacist can always supply fresh and potent ABBOTT vitamin products in a wide variety of attractive forms and package sizes. ABBOTT LABORATORIES, NORTH CHICAGO, ILL.

Specify **ABBOTT VITAMIN PRODUCTS**

Cancer Comment

CANCER CONTROL—A HALF CENTURY OF PROGRESS

It may be heartening and helpful to those interested in the cancer control program to look at the cancer pictures of 1900 and 1950.

In 1900, practically none of the present weapons used to fight cancer was in existence. Microscopes of moderate magnification were available for tissue examination. Surgery was the only recognized form of treatment but many body cavities were still closed to surgical exploration. Little or nothing was known of cancer causes or prevention. Such important laboratory procedures as tissue culture and selective animal breeding to produce constant biological types of tissues were still in the experimental stage.

Few cures were reported because practically all cancer patients were in advanced stages of the disease when first seen by a physician. Many fallacies regarding the nature, cause and treatment of the disease were widely believed. Fear of the disease was rampant and many shrank from hearing the word cancer spoken aloud.

Research efforts were devoted largely to isolation of an extrinsic causative agent, a bacterium or microscopic animal parasite. The intrinsic or biologic nature of the disease was not recognized beyond the theory of misplaced embryonic cells (the Cohnheim theory) which was widely hailed as a probable cause of all cancer.

Because there were few hopeful control measures to offer the cancer patient or the public, no attempt was made at public education. For similar reasons the subject was largely ignored in the education of medical and dental students. The condition was accepted professionally as something to be dealt with on an individual basis when encountered in medical practice.

Today, fifty years later, probably no disease holds a greater interest for the entire population than does cancer. Lay education has been extended to all groups of high school age and over. The subject has also reached the forefront of professional education. In both medical schools in Michigan, cancer is emphasized in undergraduate and postgraduate teaching and many research problems are under investigation. There is a lay cancer organization in every county in Michigan. Several hundred thousand dollars of government and private funds are spent annually in this state on cancer education, on service to the cancer patient and on research.

The public is urged to obtain periodic medical examinations by their own physicians to find cancer in early and curable stages and many are doing so. Attention to the early signs of cancer to avoid its development to the incurable stage is also being impressed on the public mind. The Hillsdale Plan for Tumor Detection is being accepted by an increasing number of medical societies in Michigan and throughout the country.

Diagnostic methods and facilities have been greatly improved. The electron microscope is revealing intimate details of cell structures and their probable place in metabolism. Biopsy permits examination of tissue without extensive surgical procedures. Studies of cells from body surfaces and fluids often will enable a diagnosis of cancer to be made before there is any microscopic evidence of the disease. The roentgen ray has proved invaluable as a diagnostic aid in many forms of cancer. The bronchoscope, gastroscope and similar instruments permit examination of most body cavities without resort to major surgery.

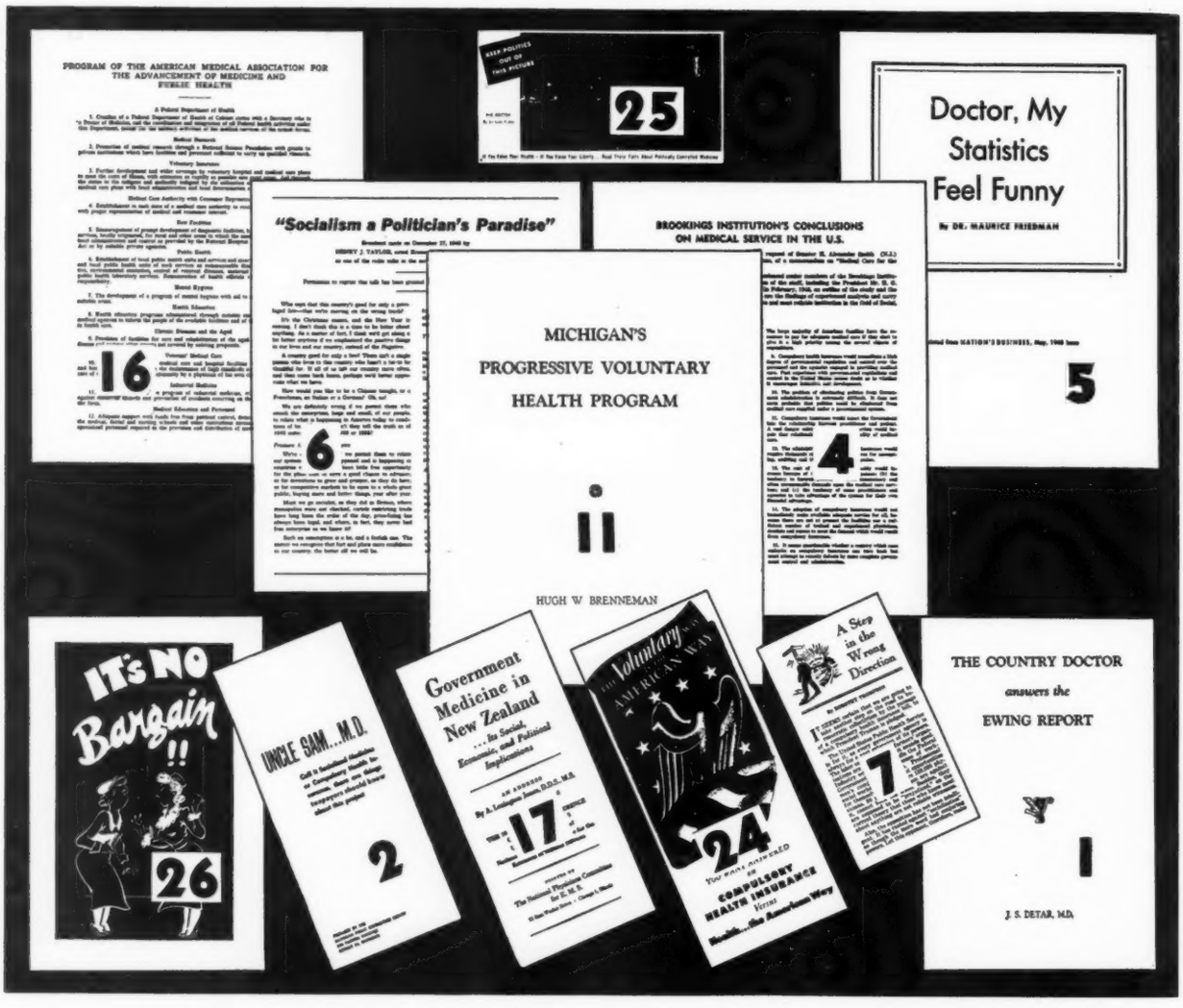
Radium and roentgen rays have been added to treatment facilities and hold a firm place along with surgery as recognized forms of cancer therapy. Hormones have proved valuable as palliative therapeutic agents in some sex-specific cancers of the opposite sex. Radioactive isotopes resulting from splitting of the atom are being intensively studied for their effect on cancerous tissue. They have not been proved to be curative and their use is still in the experimental stage.

Many causes of cancer are now known. Approximately 300 carcinogenic chemicals have been identified in recent years. Ill-fitting dental plates and the use of tobacco are closely associated with many mouth cancers. The carcinogenic action of ultra-violet light on skin tissues is well recognized.

Statistical studies have provided much valuable information regarding cancer. While records of

(Continued on Page 68)

Pamphlets Point the Way - - - - - -



PAMPHLETS WHICH HAVE PROVEN UNUSUALLY POPULAR IN THE CAMPAIGN AGAINST SOCIALISM

No. 1—THE COUNTRY DOCTOR ANSWERS THE EWING REPORT—Another MSMS publication which has been reprinted three times in order to satisfy demands for this clearcut analysis by one of Michigan's outstanding young doctors, J. S. DeTar, M.D.

No. 2—UNCLE SAM, M.D.—The first of the pamphlets to appear and because of its comprehensive review of the present situation, one that has been widely used as a source book for speakers and writers.

No. 4—BROOKINGS INSTITUTE REPORT CONCLUSIONS—The conclusions reached by the unbiased researchers of this famous investigative organization. Ranks as one of the most feared publications in the fight against socialized medicine.

No. 5—DOCTOR, MY STATISTICS FEEL FUNNY—This attractive exposition by Dr. Maurice Friedman is a refutation of the statement that draft rejection statistics during World War II indicate a need for government medicine.

No. 6—SOCIALISM—A POLITICIAN'S PARADISE—Remarks by one of America's foremost commentators. Henry J. Taylor points out the dangers of socialism as presently promoted by politicians and social planners.

No. 7—A STEP IN THE WRONG DIRECTION — Dorothy Thompson devotes her column to the dangers of taking a wrong step in a wrong direction. Her article is based upon personal observations made in countries where socialism is rife.

No. 11—MICHIGAN'S PROGRESSIVE VOLUNTARY HEALTH PROGRAM—Michigan's progress in medical pioneering and the contributions made through voluntary methods is strikingly told in this pamphlet. Here is the answer to "What are the doctors doing about broader distribution of medical care?"

No. 16—THE 12 POINTS OF THE AMA—The positive, forward looking program of the American Medical Association is listed for all to see. Valuable for both profession and laity.

No. 17—GOVERNMENT MEDICINE IN NEW ZEALAND—This becomes an even more important weapon in view of the recent action of New Zeland voters in sweeping out the Socialist Government which had held power for the past 14 years. Effectively written by A. Lexington Jones, D.D.S., M.S.

No. 24—THE VOLUNTARY WAY IS THE AMERICAN WAY—Fifty questions the people of America have been asking about Compulsory Health Insurance and fifty factual answers the American people have a right to know. This is a must for the uninformed.

No. 25—YOUR MEDICAL PROGRAM—COMPULSORY OR VOLUNTARY—Because of its convenient mailing size and comparative content this booklet has been extremely well received. In clear, concise form it compares compulsory vs. voluntary systems of medical care.

No. 26—IT'S NO BARGAIN—Here is the newest and most universally accepted of all available pamphlets. Written by a woman for women readers its content has attracted comment from all, men and women. Written and published by the Woman's Auxiliary to the Michigan State Medical Society.

PR In Practice

USE OF MEDIA—DISTRIBUTION OF LITERATURE

The success of a medical public relations program depends upon the practical application which is made of the various media of communication and expression available. In the initial article in the December issue, the use of visual displays was discussed and illustrated with photographs of actual displays prepared by members of MSMS. This month's article covers, the field of pamphlet publication and distribution as developed by the Michigan State Medical Society and presented by request to the annual meeting of the AMA last June.

Distribution of literature is of primary importance in our considerations. We have to ask ourselves such questions as: "Who is going to get the pamphlet?", "Why are you giving the pamphlet to them?," "What sort of action should the pamphlet bring?," "Where are the persons to whom you plan to give the pamphlet?" and "How are you going to get the pamphlet to them?" When we have the answer to these questions, we have the information which leads into the active tangibles of preparation and publication.

Any literature has value only when it is read by the person whom the writer had in mind when original preparation was made. Large supplies of pamphlets and broadsides piled in storerooms of state and county medical societies are not only *not doing a job,* but they constitute a fire hazard. For this reason, then, it becomes incumbent upon those receiving literature to disseminate that material immediately upon its arrival. It is also advisable for medical societies to maintain an inventory of at least two weeks' supply of literature. In this way, requests for material can be met without unnecessary delay, and the public relations value of the program is further enhanced. In the case of county medical societies, the question isn't nearly so important due to the short distances between supplier and distributor.

On the state level, it was found that the services of a professional mailing organization would more than balance the additional expense involved in buying equipment, rental of space, and hiring of extra employes. By using this method, the State Society office has eliminated a storage problem and developed an efficient method of distribution.

For example: Doctors and friends of the profession throughout the state are periodically supplied with printed requisition forms listing the pamphlets and other items which are available for use in quantity. Each pamphlet is listed, described, and numbered. There is room for designation of quantities desired as well as for signature of the requesting party. When the completed form arrives in the MSMS office, it is checked for error and over-order and forwarded to the office of the commercial organization for filling. The mailing organization then fills the requisition and puts the ordered material into the mails or express the same day. Staff members of this organization record the amount of postage used, keep a perpetual inventory and make necessary reorders and reprintings of pamphlets which are in low supply. By utilization of this method, the actual details of making distribution of literature is held to a few moment's work each morning by a secretary in the State Society office.

Additionally, a small supply of available material is kept in the Public Relations office for filling of single requests where only a few copies are desired.

With the activities of an extensive educational campaign, it is obvious that considerable expense is involved in making distribution of campaign materials. To this end, an increased and effective activity on the part of local medical societies can do much to eliminate some of the expense. However, the State Society, with its paid personnel, is usually in a more advantageous position than the smaller local groups that function without benefit of paid employes.

The opportunities are limitless for distribution; *the key, however, lies in getting the pamphlets to the right person, in the right way, and at the low-*

est cost. For example: a pamphlet picked up in the doctor's waiting room is not as effective as a pamphlet handed the patient in the waiting room by a personable receptionist who says, "I know you are interested in the important problems facing the country today and will want to read this pamphlet." And even this is not as effective as for the doctor himself to use the same approach and *urge* the patient to *express himself* after he learns the right facts in the case. You will find, of course, that distribution to the layman depends essentially upon the interest of the doctor, and if that interest is sufficiently stimulated and sustained, the ways and means will be forthcoming on the local level in many intriguing and effective ways.

In distribution of literature, it is well to remember the part the Women's Auxiliary can play. Auxiliary members are in a good position to place pamphlets in beauty parlors and other places where women congregate, to contact club meetings and to enclose booklets in letters and correspondence.

There are many, many avenues of distribution for literature in addition to doctors' offices which can be conveniently and efficiently used. Drug stores will often use posters and supplement the display by wrapping pamphlets with all purchases. Public libraries and, particularly, school libraries, when properly approached, will put the materials into the hands of those who are interested. Mailing by interested groups is usually possible and constitutes an effective means for reaching particular groups. For example, the farm audience can be reached through Grange and Farm Bureau mailings. These organizations are pleased to cooperate, and the farmer, receiving material through his own group, is more likely to read and seriously consider the import of the pamphlets. Pharmaceutical groups, bar associations, insurance groups and many others are all willing to co-operate after contact is made by those spearheading a campaign.

Many business houses have distributed pamphlets in their pay envelopes, while churches have used them as subjects for study groups. Public meetings are also good outlets, especially when materials are left on each seat in the auditorium.

Further examples of methods of distribution should include the work of a prominent western Michigan doctor who took the opportunity of placing small pamphlets in the open windows of parked cars as he walked to his office.

Ingenuity plays an important part in effective distribution, and each area and locality will find that problems incident to the area will require separate treatment. In the manner of treating the problem lies the effectiveness of the campaign.

A word of caution must be voiced in the use of literature as a public relations medium. It is one of the most expensive of the media, but it appears to be the cheapest. It is one of the most effective mediums, if properly used—and is one of the dangerously overrated mediums, if improperly used. It is based upon participation by the consumer, and unless it results in immediate action its effect is lost, for the emotional impact is seldom of long duration.

Editorial Bouquets To—

In my first "orchid throwing" of the new year I'd like to thank every member of the Society and the Auxiliary for their exemplary efforts during the year past. Your hard work on the CAP Program has paid handsome dividends and your co-operation indicates that the 1950, the "Mid-Century" year will attract your attention and time to complete the job against a Welfare State . . . Thank you all . . . Now for individual workers . . . **A. F. Bliesmer, M.D., St. Joseph physician, is commended along with the members of his County Medical Society for the excellent public relations gained through the appearance November 7, of Ernest E. Irons, president of the American Medical Association . . . Dr. Irons spoke to the Economic Club of Southwestern Michigan, and his remarks were broadcast as well as generously reported in the local press of that area** . . . Horizontal activities of the Wayne County Auxiliary is moving into high gear under the Inter-Organizational Committee composed of Mrs. W. G. Mackersie, Mrs. Paul H. Lippold, Mrs. W. W. MacGregor, Mrs. S. W. Insley, Mrs. I. C. Berlien, and Mrs. M. D. MacQueen . . . **George E. Chittenden, M.D., Detroit, is commended for his most exhaustive study of all literature relating to the problem of socialization** . . . McClellan Conover, M.D., Flint, has prepared a mimeographed sheet for his office visitors in which they indicate a desire for further information or answers to questions . . . He re-

(Continued on Page 26)

Editorial Bouquets

(Continued from Page 24)

ports an unusual interest through this approach . . . **Ronald E. Clark, M.D., Detroit, recently returned from a visit to England, is passing out English thrupences (equivalent to a shoe shine in this country)—He indicates that this is the amount the average English doctor receives per call** . . . S. W. Hartwell, M.D., Muskegon, observed that literature wasn't being picked up—decided to place some on each waiting room chair . . . a kindly old lady arrived early in the morning, did her good deed for the day by picking up each pamphlet and replaced them in a neat pile on the waiting room table—moral is, you can lead them, but you can't make them read . . . **Mrs. George Waldbott, Detroit, made brilliant defense of voluntary medicine through columns of the Vassar College Alumni magazine . . . Her article has been cited by the AMA and reprinted in several medical journals** . . . The utilization of the film "Lucky Junior" is aiding the effectiveness of rural and urban club meetings addressed by Leo F. Chess, M.D., Reed City physician . . . **The members of the Muskegon Chamber of Commerce recently received copies of The U. S. Chamber's effective pamphlet "You and Socialized Medicine"** . . . Also Muskegon: More than 100 representatives of civic organizations in this area were entertained at a dinner meeting by the Muskegon County Medical Society recently. This is one of the meetings planned by this active Society to widen activity against government paternalism . . . **S. A. Fiegel, M.D., energetic Sturgis doctor, is spreading his talents beyond Michigan as he makes junkets into Indiana, spreading the cause of good government and voluntary medicine** . . . Words of praise are also due the Councilors and District CAP leaders for their note-worthy handling of the various district meetings held throughout the past several weeks . . . as a result of these get-togethers the horizontal program will gain added momentum through active Speakers Bureaus . . . **Credit J. E. Manning, M.D., Saginaw, with capable assists for the program as he speaks in and around his city** . . . Recent trip by PR Field Secretary reveals that everything freezes in the Upper Peninsula but the CAP activities as witnessed by the enthusiastic District meetings . . . **State Auxiliary President, Mrs. Don. R. Wright, and organizational chairman, Mrs. Oscar Stryker, also stepped up Auxiliary and CAP program in the UP as result of a junket through the area** . . . In closing don't forget the County Secretaries-Public Relations Conference on January 22 . . . plans for the future will be presented as well as several outstanding national personalities from the nation's capital. . . .

L. W. HULL, M.D., *Chairman,*
Special Committee on Education

From the P.R. Mailbag:

"This (It's No Bargain) is the best publication we have had yet . . . we congratulate the Woman's Auxiliary to the Michigan State Medical Society for the very fine publication. More power to them."

MRS. JOHN Z. BROWN, *President*
Auxiliary to the Utah State Medical Society

"Please accept our congratulations on your pamphlet "It's No Bargain." It certainly should be most effective."

H. T. CARAWAY, M.D., *Secretary*
Montana State Medical Association

"Your new pamphlet "It's No Bargain" is certainly a most excellent approach to the campaign issue. . . . We are interested in knowing reprint prices and privileges."

JAMES G. BURCH,
Connecticut State Medical Society

BROOKINGS INSTITUTE PRESIDENT WARNS OF SECURITY PLANS

Dr. Harold G. Moulton, president of the Brookings Institution, believes the American economy is not strong enough now to carry "the cumulative burden of the social over-head."

In an address to 2,500 delegates to the 54th Congress of American Industry, sponsored by the National Association of Manufacturers, Dr. Moulton stated:

"If the current trends are not checked, the mounting tax load and the continuance * * * of fiscal uncertainty will * * * undermine private enterprise by killing the incentives to take the risks essential to a dynamic, expanding economy."

In only two years out of the last twenty has the Federal Treasury had a surplus of revenues over expenditures, Moulton pointed out. He stated:

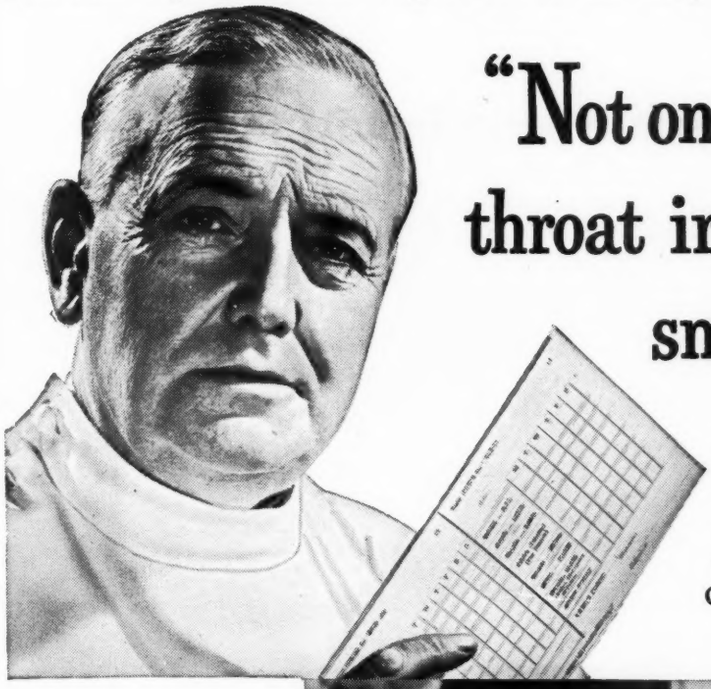
"The resulting vast rise in the public debt, expansion of social services and of military outlays have diverted an ever-increasing proportion of the national income to the Treasury in the form of taxes.

"Even a moderate recession, such as a 20 per cent decline, would involve a drop in tax receipts of something like 16 to 18 billions of dollars. We possess no margin of safety."

The Administration is seeking an expanded security program which, with veterans' benefits, may cost by 1960 somewhere between 20 and 28 billions of dollars annually, and as much as $36,000,000,000 by 1980, the economist estimated.

"What we are attempting is to decide now what burdens our children and grandchildren shall assume in connection with these spectacular programs," he told the National Association of Manufacturers.

Throat Specialists report on 30-day test of Camel smokers:



"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

Long Island housewife Edna Wright, one of the hundreds of people from coast to coast who made the 30-day Camel mildness test under the observation of throat specialists.

According to a Nationwide survey:

More Doctors Smoke Camels

than any other cigarette

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel!

H. R. 6000 (Extension of Social Security)

On October 5, 1949, the United States House of Representatives passed H. R. 6000 by a majority of 333 to 14.

This is history now—but in that history it would be well to analyze carefully the implications in this seeming victory for the Administration. The bill, one of the most far reaching and dangerous extensions of social security ever to be presented, will be before the Senate in January, 1950. When it makes its appearance in its recognized role as a "political football" it will be up to the thinking people of America to protest long and loudly to their friends in the U. S. Senate.

The following report is designed to help you in taking action. In it you will find reasons why the proponents favor H.R. 6000 and in rebuttal, the views of the minority members of the House Ways and Means Committee.

The facts are here—The use you make of them and the subsequent action you and your friends take will determine the future of a great America which today, *is already too far down the road to a Welfare State.*

WHAT YOU CAN DO NEXT

In the days that lie ahead it will be your responsibility to see that your two Michigan Senators and those from other states are informed by letters and telegrams requesting *ONLY ONE THING—TO OPPOSE H.R. 6000.* Use one or more of the following reasons for asking its defeat:

1. This extension of Social Security, as planned, is not financially sound. Only a complete change in its concept and administration would make it so.

2. Compulsion is to be applied to 11,000,000 new persons who have never tasted Federal compulsion. This includes most self-employed persons.

3. If nearly all the working population is brought under Social Security there is every reason to fear that groups now exempted, farmers, lawyers, physicians, etc., would not long be free.

4. The new taxes proposed will inevitably be passed along to the consumer through higher prices.

5. The Government has not held Social Security taxes inviolate and cannot be expected to do so in the future.

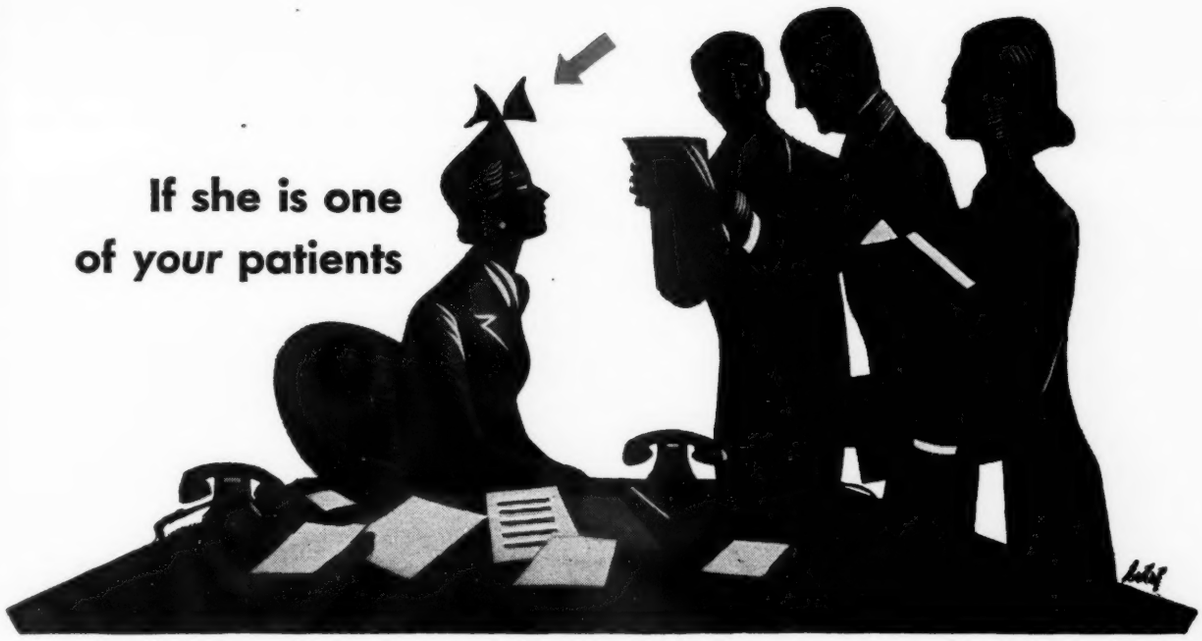
6. Future committments made in H.R. 6000 are so great as to cause the insolvency of the United States.

7. The expensive wage records systems of the Social Security system should be abolished.

8. The Federal Government would be authorized to make direct payments to doctors of medicine thereby passing a hurdle on the road to socialized medicine.

9. In addition to writing Michigan's Senators A. H. Vandenberg and H. Ferguson, it would be well to contact the members of the Senate Finance Committee where H.R. 6000 will first be considered. The members are: Democrats—Walter F. George, Ga., Thomas Connolly, Texas, Harry F. Byrd, Va., Edwin C. Johnson, Cal., Scott W. Lucas, Ill., Clyde Hoey, N. C., Republicans—Eugene V. Milliken, Colorado, Robert A. Taft, Ohio, Hugh Butler, Nebraska, Owen Brewster, Maine, Edwin Norton, Pa.

Any member of the Michigan State Medical Society who desires further explanatory information and H.R. 6000 may receive a copy of the pros and cons by writing the Executive Offices, 2020 Olds Tower, Lansing 8.



...Your help *now* may spell the difference between unprovided-for old age and economic security.

Women in business who are nervous, emotionally unstable and generally distressed by symptoms of the climacteric almost inevitably experience a reduction in efficiency as well as earning power.

***"Premarin"** offers a solution. Many thousand physicians prescribe this naturally-occurring, oral estrogen because...*

1. *Prompt symptomatic improvement usually follows therapy.*
2. *Untoward side-effects are seldom noted.*
3. *The sense of well-being so frequently reported tends to quickly restore the patient's confidence and normal efficiency.*
4. *This "Plus" (the sense of well-being enjoyed by the patient) is conducive to a highly satisfactory patient-doctor relationship.*
5. *Four potencies provide flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).*

Ayerst

*While sodium estrone sulfate is the principal estrogen in **"Premarin,"** other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.*

"PREMARIN"®

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

ESTROGENIC SUBSTANCES (WATER-SOLUBLE)
also known as CONJUGATED ESTROGENS (equine)

Ayerst, McKenna & Harrison Limited 22 East 40th Street, New York 16, New York

Michigan Medical Service

BOARD OF DIRECTORS—1949-1950

		Term Expires
REPRESENTING THE MEDICAL PROFESSION		
Robert H. Baker, M.D.	Speaker, House of Delegates, Michigan State Medical Society Pontiac	1951
E. C. Baumgarten, M.D.	Surgeon Detroit	1951
Leon M. Bogart, M.D.	Surgeon Flint	1951
A. S. Brunk, M.D.	Treasurer, Michigan State Medical Society President, Michigan Health Council Detroit	1952
E. I. Carr, M.D.	President, Michigan Foundation for Health Education Lansing	1952
J. S. DeTar, M.D.	Councilor, 14th District, Michigan State Medical Society Milan	1952
L. Fernald Foster, M.D.	Secretary, Michigan State Medical Society Bay City	1950
W. B. Harm, M.D.	Councilor, 17th District, Michigan State Medical Society Detroit	1951
Wilfrid Haughey, M.D.	Editor, "Journal" Michigan State Medical Society Vice President, Michigan Medical Service Battle Creek	1952
W. A. Hyland, M.D.	Delegate, American Medical Association Grand Rapids	1950
W. H. Huron, M.D.	Delegate, American Medical Association Iron Mountain	1950
P. L. Ledwidge, M.D.	Past President, Michigan State Medical Society Secretary, Michigan Medical Service Detroit	1950
R. L. Novy, M.D.	President, Michigan Medical Service Delegate, American Medical Association Detroit	1951
E. A. Oakes, M.D.	Councilor, 9th District, Michigan State Medical Society Manistee	1950
Grover C. Penberthy, M.D.	General Surgeon Detroit	1950
Philip Riley, M.D.	Councilor, 2nd District, Michigan State Medical Society Jackson	1950
E. F. Sladek, M.D.	Immediate Past President, Michigan State Medical Society Traverse City	1952
REPRESENTING HOSPITALS		
Kenneth Babcock, M.D.	Director, The Grace Hospital Detroit	1950
E. D. Barnett, M.D.	Superintendent, Harper Hospital Detroit	1952
M. F. Capra	Administrator, McPherson Memorial Hospital Howell	1951
A. C. Kerlikowske, M.D.	Director, University Hospital Ann Arbor	1950
William Rottschaefer, M.D.	Assistant Director, University Hospital Ann Arbor	1951
Ronald Yaw	Director, Blodgett Memorial Hospital East Grand Rapids	1952
REPRESENTING THE PUBLIC		
Harry Becker	UAW-CIO Social Security Department Detroit	1951
Carleton Fox, D.D.S.	Oral Surgeon Detroit	1952
John Reid	State Commissioner of Labor East Lansing	1951
W. I. Stoddard	Vice President, Michigan National Bank Treasurer, Michigan Medical Service Grand Rapids	1952

fits my x-ray needs to a "T" — and my budget, too! it's a Picker "Meteor"

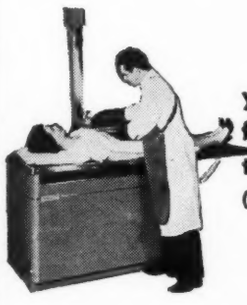
"I want to be able to screen a chest or an extremity whenever it seems indicated. I want to be able to radiograph a chest as part of every physical examination I make — especially of new patients. I want to be able to fluoroscope and radiograph suspected fractures in the occasional emergency cases that come to my office.

I can do all that and more, *quickly* and *easily* with the Picker 'Meteor.*' Its 15 MA capacity is ample for my needs. I've had no trouble finding room for it, because it doubles as an examination table. It's a *quality* unit, made by Picker X-Ray . . . they're the people who built the Army Field X-Ray Unit we both worked with during the war. And it certainly is easy on my budget . . . cost far less than I thought I'd have to lay out for such fine equipment."

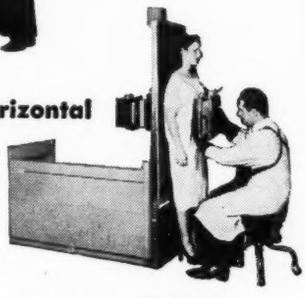
Maybe your situation parallels Dr. Jones' . . . or maybe it's altogether different. In any case, you can depend on the local Picker representative for unbiased advice, because the Picker line is a full line, embracing apparatus in *every* range, for *every* purpose.

*patents pending

it's simple, sure, easy to operate



you change easily from radiography to fluoroscopy (or vice versa)

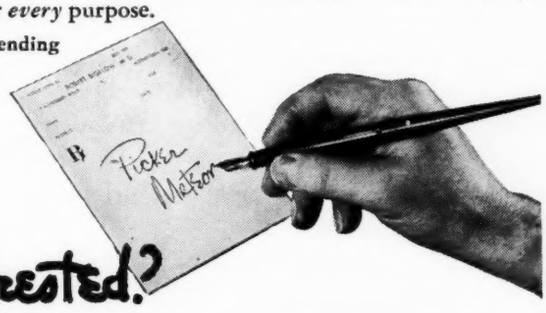


vertical or horizontal (full length of head and torso)

it's low-priced at $1495

and above all, it's

Picker x-ray



interested? just do this

jot Picker "Meteor" on a prescription blank, and send it to us for details. Or, if you prefer, call in your local Picker representative for the story.

PICKER X-RAY CORP.
300 Fourth Ave., New York 10, N. Y.

PICKER IN MICHIGAN IS AT 1068 MACCABEES BLDG., DETROIT 2, *(Temple 1-7171)*

Michigan Health Council Elects J. S. DeTar, President

Michigan's progressive health program took another step forward at the Annual Meeting of the Michigan Health Council, held at the Detroit-Leland Hotel, Detroit, on November 30.

Fifteen state level health organizations pledged support to the expanded activities' program of the

J. S. DeTar, M.D.

Council which has as one of its major projects the organization of Community Health Councils throughout the state, designed to study, analyze and promote local health projects through group planning in the community.

Retiring President A. S. Brunk, M.D., Detroit, pointed out that eleven Michigan community organizations have accepted Associate Membership in the Michigan Health Council, and that organizational activities are underway in seven other counties in various parts of the state.

The Council, which was originally set up and supported by M.S.M.S., Michigan Hospital Service, Michigan Medical Service and Michigan Hospital Association, still has the backing of these groups. An amendment written into the By-Laws in November, 1948, provided opportunity for other Michigan organizations having a major interest in health to become voting and contributing members.

Dr. Brunk reviewed the progress of the Council since it was launched on its expanded program last February, He explained that 11 Michigan organizations interested in health on a state-wide level have accepted invitations to membership in the Council, and that seven other such health groups are planning to become affiliated with the Council.

Listed among Michigan organizations which have taken membership this year are: American Cancer Society, Michigan Division, W. K. Kellogg Foundation, Michigan Education Association, Michigan Agricultural Conference, Michigan Farm Bureau, Michigan Foundation for Medical and Health Education, Inc., Michigan State Grange, Michigan Health Officers Association, Michigan Home Economics Association, Michigan Public Health Association, Michigan Rural Teachers Association, Michigan Tuberculosis Association.

Dr. DeTar Honored

In accepting a unanimous vote for president, J. S. DeTar, M.D., Milan, encouraged continued support of the Council's program by the present membership and promised further expansion of the Council's activities in 1950. Dr. DeTar explained that "good health begins in and belongs to the community, and we must do everything possible to assist each and every Michigan community to build its own health program." He explained that "the Michigan Health Council stands ready to co-operate with any Michigan community in the formation of a local health council, free of charge," and encouraged local groups to take advantage of this service which is available to them.

Graham Davis of Battle Creek, H. W. Brenneman of Lansing and L. Gordon Goodrich of Detroit, were re-elected as Vice President, Secretary and Treasurer, respectively.

Re-elected to the Board of Trustees were: Graham Davis, Battle Creek, William S. McNary, Detroit, R. L. Novy, M.D., Detroit, A. S. Brunk, M.D., Detroit, L. Gordon Goodrich, Detroit, O. K. Engelke, M.D., Ann Arbor, and David Littlejohn, M.D., Dearborn. Others elected to serve on the expanded Board of Trustees were Kenneth Babcock, M.D., Detroit, E. I. Carr, M.D., Lansing, B. D. Dann, Muskegon, J. S. DeTar, M.D., Milan, Mrs. Marjorie Karker, Lansing, and G. C. Stucky, M.D., Charlotte.

The Annual Report presented to the membership by E. H. Wiard, Executive Secretary of the Council, reviewed ten major projects which have been accomplished this year and proposed seven new projects for consideration. President DeTar was authorized to appoint a committee on projects to study and recommend action to be taken on the proposals.

HEALTH NEEDS AND HEALTH CARE IN MICHIGAN

Abstract

By Charles R. Hoffer, Duane L. Gibson,
Charles P. Loomis, Paul A. Miller,
Edgar Schuler and John F. Thaden,
Social Research Service, Michigan State College
East Lansing, Michigan

THIS STUDY presents the results of a state-wide survey of a sample of 1,113 households scientifically selected from the rural and urban areas of the state. By use of a selected and tested list of twenty-seven symptoms the study showed that more medical care is needed throughout the population. The amount of unmet need for medical attention, however, is greatest in the open country. Among the factors associated with an increase of unmet medical need were: low income; lack of education, especially for families in which the education of the female head is eighth grade or below; size of medical service area, if under 2,000 in population; miles to the nearest town when the distance exceeds ten miles.

The families reported that 43 per cent of the individuals who had one or more untreated symptoms ought to see a doctor. When asked why such persons had not seen a doctor the following reasons, listed in order of frequency, were: too expensive; lack of time; symptom not thought to be serious; neglect; belief that doctor is unable to help condition; and then a list of "other" or miscellaneous reasons.

The data of the study showed that slightly more than two-thirds of the families go to one doctor only for most of their ills. About one family in each six goes to more than one doctor, and approximately one family in each seven reported that they had not established contact with any doctor.

The section of the study dealing with practices and opinions regarding health services showed that the qualities of a doctor that people like most are pleasing personality and ability to diagnose and treat illness. They dislike most of all ineffective treatment and what they judge to be poor techniques in administering treatment. About four-fifths of the families succeeded in getting a doctor's help when they needed it. When a family could not get a doctor, the failure was due in about four times out of ten to one of the following reasons: either the doctor was not on duty (afternoon off, Sunday, or holiday); or the doctor was too busy. In general, people believe that more doctors are needed in Michigan communities; but about seven persons out of every ten do not know how a community could endeavor to get a doctor if it needed one. Among almost one-half of the families interviewed, one or more family members had gone to a doctor who was not an M.D., usually an osteopath.

About 34 per cent of all families in the sample had insurance to pay for a part or all of hospital expenses for at least one member of the family. For fees for surgery, the corresponding percentage was twenty-nine. For a part or all of doctors' services other than surgery only 12.6 per cent of the families had such coverage for at least one family member. An illustration for such coverage would be the medical service that a man might receive at the place where he works.

A high percentage of the families thought insurance or prepayment plans for paying hospital or doctor bills are a good idea. Only about one informant in each five, however, had heard of any kind of a government sponsored prepayment plan for paying doctor and hospital bills. Yet, when asked if they thought a government plan to pay for doctor and hospital bills was a good idea or not, 45.9 per cent thought it was a good idea and 17.9 per cent were uncertain.

In the part of the study dealing with community and public health matters the data showed that programs to have children immunized or vaccinated for diptheria, smallpox and whooping cough are needed. About one person in each ten was concerned about a specific health problem in his local community. Most of the problems mentioned pertained to some aspect of sanitation, although 2 per cent of the informants mentioned lack of doctors as a major community health problem. Only about one person in each five stated that he had heard about community health councils, but a majority of the informants thought a community health council or similar organization would be a good idea.

A total of 41.4 per cent of the 717 informants reported that they had not heard or read about the Michigan State Medical Society. Among the 376 who said they had heard about it, 53.2 per cent thought it worked for the interest of both the people and the doctors. Forty-one per cent of the 376 informants said they liked what the Michigan State Medical Society does. Half of the number were not sure whether they liked its activities or not.

Summary (Part I)

Briefly stated, the findings of the survey regarding unmet need for medical attention show that more medical care is needed throughout the population. The amount of unmet need, however, is greatest in the open country and in villages. Metropolitan areas correspond very closely to open country areas in regard to the proportion of the population having unmet need for medical care. All of the twenty-seven symptoms used in the schedule were reported one or more times. Those which tended to occur most frequently in all sample areas were pains in the joints, toothache, poor vision and

(Continued on Page 36)

This is a report of a state-wide survey to the Michigan State Medical Society and Michigan Foundation for Medical and Health Education Inc. by Social Research Service, Michigan State College, East Lansing, September, 1949.

(Continued from Page 34)

unexplained tiredness. The occurence of symptoms showed a tendency to increase as the age of individuals increased.

Among the socio-economic factors associated with unmet need, gross family income was an important factor in all sample areas. Miles to the nearest town having a doctor, an ecological factor, was also associated with amount of unmet need. The unmet needs increased with distance. Population of the medical service area appeared to be associated with the lower levels of health and health care if the population was under 2,000. There was a tendency for the level of health and health care to go down as the education of years in school of the head of the family decreased.

The data show that slightly more than two-thirds of the families go to one doctor only for most of their ills. About one family in each six go to more than one doctor, and approximately one family in seven reported that they had not established contact with any doctor.

Eighty-eight per cent of the families reported that the doctor they usually consulted was an M.D. In the total sample 3.1 per cent of the doctors were non-M.D.s; but in villages the corresponding percentage was 4, and in urban areas, 3.9.

During the period of six months immediately preceding the date of the interview, it was ascertained that 65.9 per cent of the individuals had not consulted a doctor at all. Thirteen and three-tenths per cent of the individuals have consulted a doctor at his office one time. Among the remainder, 1.8 per cent have consulted a doctor twenty-one or more times. There were not marked differences among the open country, village, metropolitan and urban families regarding the number of times a doctor was consulted. Likewise, care of the patient in his home by a doctor occurred in all areas with a high degree of uniformity. About 7 per cent of the population had received such care during the six months' period.

Dental service was less general among the population than was medical care. Only 22.6 per cent of the population had received dental care in the period of six months, whereas 34.1 per cent of the population had received at least some medical care. About 14 per cent of the population had seen a dentist at least one time during the six months' period, and a total of 7.8 per cent of the population had received dental services more than one time.

The families reported that 43 per cent of the individuals who had one or more untreated symptoms ought to see a doctor. When asked why such persons had not seen a doctor, the following reasons, listed in order of frequency, were given: too expensive; too far, distance too great; lack of time; symptoms not thought to be serious; neglect; belief that doctor was unable to help condition; and then a list of "other," or miscellaneous reasons.

Among those persons who consulted a doctor the data show that 17.5 per cent, more than one in each six, were advised to go to a hospital; and 14.6 per cent actually went. A slightly higher proportion of the rural population than of the urban population were hospitalized.

Summary (Part II)

The outstanding qualities that people like about a doctor are pleasing personality and professional efficiency. They dislike most of all poor, ineffective treatment and what they judge to be poor techniques in administering treatment. In general, however, the people expressed satisfaction with the help they had received from doctors. When they were dissatisfied, the most common complaint was poor treatment and bad techniques.

About four-fifths of the families succeeded in getting a doctor's help when they needed it. When they could not get a doctor, it was due in about four times out of ten to one of the following reasons: either the doctor was not on duty (afternoon off, Sunday, or holiday); or the doctor was too busy. In 13.9 per cent of the instances the fact that the doctor would not make house calls accounted for the failure to get his help. When the services of the doctor could not be obtained, the family usually called another doctor. The results of failure to get a doctor's help varied. In one-fourth of the instances another doctor treated the patient satisfactorily; but in 9.3 per cent of the cases the patient got worse; and in 6 per cent of the instances the patient died.

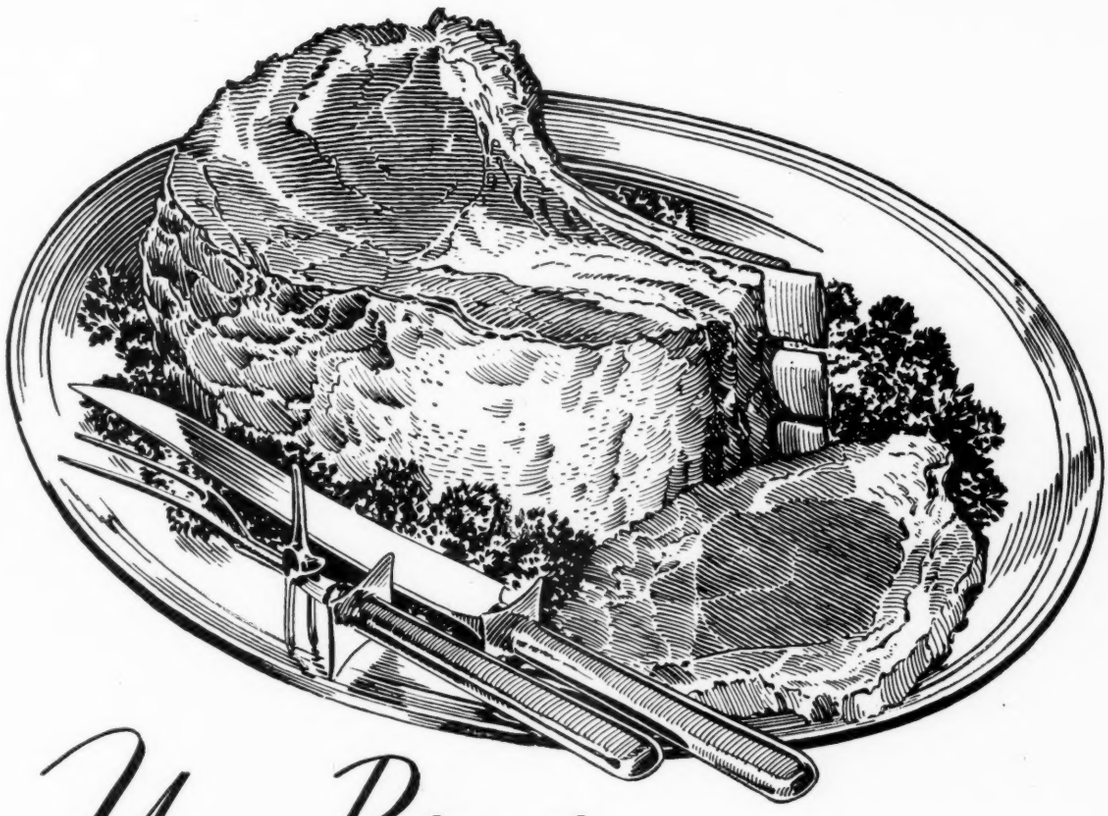
In general, people believed more doctors are needed in Michigan communities; but about seven persons out of every ten do not know how a community could endeavor to get a doctor if it needed one. Only about one-third of the residents in Michigan have heard about group practice on the part of doctors; but 46 per cent believe they prefer a group plan rather than going to a doctor who practices alone.

Among the families interviewed, in almost one-half of the total, one or more members had gone to a doctor who was not an M.D. More often than not the doctor who was the non-M.D. was an osteopath. In about three times out of ten, the non-M.D. which the family went to was a chiropractor. The most frequent ailment which the patient had when he went to an osteopath was "back trouble." General ailments ranked second in the list of causes. Opinions about the training of M.D.s and osteopaths varied, but 46 per cent of the informants stated that they did not know what the difference was.

The survey showed that one or more members of 63 per cent of the families had been hospitalized within the last year or two. In most instances, the families were satisfied with the services they received from the doctors while in the hospital. About 30 per cent, however, were dissatisfied with the accommodations and services that they received. The dissatisfaction pertained to lack of nurses, high rates and poor food.

About 60 per cent of the families had had insurance to pay for a part or all of the hospital bills for at least one family member, although in a majority of cases all eligible members of the family were included in the plan.

(Continued on Page 38)



Your Patients...

And the Meat They Eat

The established relationship between sound dietary planning and a state of maintained good health emphasizes the nutritional importance of meat, man's favorite protein food.

Not only does meat taste good, but of greater significance, it provides a host of nutritional benefits. Developments in the field of nutrition* have proved that complete protein—the kind that meat supplies in abundance—aids in building and maintaining immunity, hastens recovery after acute infectious diseases and following injury and burns, promotes health during pregnancy, aids in the growth and development of husky children, and is needed to maintain everyone in top physical condition.

No matter from what walk of life your patients come, and whether their pocketbooks demand economy or permit satisfaction of that urge for the fanciest cuts, meat gives them full value for their money.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

American Meat Institute

Main Office, Chicago...Members Throughout the United States

(Continued from Page 36)

Approximately one-half of the families had insurance for at least one member to pay for a part or all of the fees for surgery; but only a fourth participated in prepayment plans to pay for any kind of doctor services other than surgery.

Blue Cross insurance accounted for 36.2 per cent of the hospital insurance, 35.4 per cent of the insurance for surgery, and 29.8 per cent of the insurance for doctors' fees. Of the 717 informants, a total of 299 (41.6 per cent) stated that one or more members of the family had carried hospital insurance and dropped it. The most frequent cause for dropping was "quit work at the place where person participated in the group plan." Among the 299 dropping insurance, 27.8 per cent were families who had Blue Cross insurance.

A high percentage of the families thought that insurance or prepayment plans for paying hospital and doctor bills are a good idea. Only about one informant in each five, however, had heard of any kind of a government-sponsored prepayment plan for paying doctor and hospital bills. Yet, when asked if they thought a government plan to pay for doctor and hospital bills was a good idea or not, 45.9 per cent thought it was a good idea and 17.9 per cent were uncertain. Only 28 per cent definitely stated that it was not a good idea. Questions in which the term "socialized medicine" was used showed that 67.9 per cent of the 717 informants had not heard about it; 25.2 per cent had heard about it, and the remainder were uncertain. Those who had heard about it thought that socialized medicine would be especially advantageous for families with low incomes. A certain number, about 6 per cent, thought more people would be taken care of. On the other hand, in the opinion of the informants, the chief disadvantage would be that it would add to government control. About one person in each eight mentioned that objection. About 7 per cent thought that under a plan of socialized medicine, the quality of medical care would be lowered.

Summary (Part III)

The survey showed that one or more members in one-fourth of the families had been personally advised or examined by a representative of their local health department. Proportionately more families in metropolitan areas had such contacts than the families in other areas. The percentage for those areas was 30.4. Immunization for diphtheria was reported for 63.4 per cent of the children six months to sixteen years of age. The lowest percentage for that item was found in urban areas, and the highest for open country residents. Immunization for whooping cough was less general because only 42.5 per cent of the persons six months to sixteen years of age were reported as immunized and had not had the disease; and an additional 7.8 per cent were reported as vaccinated and had the disease. Vaccination for smallpox was reported for 69.2 per cent of all individuals over one year of age included in the sample. The general conclusion to be made from these percentages is that the programs to have children vaccinated for the diseases under consideration should be intensified.

It appears that approximately one person in each ten is concerned about a specific health problem in his local community. Most of the problems pertain to some aspect of sanitation, although 2 per cent of the informants mentioned lack of doctors as a major community health problem. Only about one person in each five had heard about community health councils; but a majority of informants thought a community health council or similar organization would be a good idea.

Using the Michigan State Medical Society as an illustration of organizations working in the field of health, the 717 informants were asked if they had heard or read about it. A total of 41.4 per cent reported that they had not heard or read about it. Among the 376 persons hearing or reading about it, 53.2 per cent thought it worked for the interest of both the people and the doctors. A third of the total were uncertain, and 9.3 per cent definitely stated that they thought it worked for the interest of the doctors. However, 41 per cent of the 376 informants stated that they liked what the Michigan State Medical Society does. A half were not sure whether they liked its activities or not.

The radio program "Tell Me, Doctor" had been heard by one of the members in one-fourth of the households included in the survey, and about 40 per cent of the persons who had heard about it listened to it at least one time per week. Only 22.7 per cent of those informants knew that the program "Tell Me, Doctor" was sponsored by the Michigan State Medical Society.

A. S. Brunk, M.D., Detroit, Past President of the Michigan State Medical Society and Immediate Past President of the Michigan Council, was honored by the Health Council on the occasion of the MSMS Annual Secretaries-Public Relations Conference in Detroit on January 22. Dr. Brunk was presented with a testimonial plaque commemorating his long-time service as President and guiding spirit of the Michigan Health Council.

* * *

Alfred Heacock Whittaker, M.D., Detroit, President of the American Association of Industrial Physicians and Surgeons, will be honored by a testimonial dinner in Ann Arbor on March 29. This banquet, closing the first annual Michigan Industrial Health Conference, will be held at the Allenel Hotel. The Conference is sponsored by the Michigan Association of Industrial Physicians and Surgeons, the U. of M. School of Public Health, the U. of M. Medical School, Wayne University College of Medicine, Industrial Health Division of the Michigan Health Department, and the Industrial Health Committee of the Michigan State Medical Society.

Political Medicine

DRISCOLL COMMENTS ON SOCIALIZED MEDICINE

Charles B. Driscoll writes a column in the Daily Newspapers "New York Day by Day." In the installment for November 30, 1949, he writes:

"I believe that the people understand that compulsory federal health insurance means eventual socialized medicine, such as now exists in England, and it is my personal opinion that the people do not want that.

"Still, our government, without referendum, has placed us in a position that makes us easier to sell on socialized medicine than we were a year, two or 10 years ago.

"We are supporting, out of our taxes, the British socialized state. One of the heaviest expenses which we pay out of our pocketbooks is for socialized medicine in England.

"Doctors and dentists and eye-glasses are free, or almost free, in England, but we are paying those doctors and dentists and eyeglass makers handsomely out of our taxes. Doctors are making more money than they made in the evil old days of capitalism and honest competition."

This is another piece of misinformation given to the millions of readers who accept Driscoll's word as gospel. According to the *British Medical Journal,* and all information we are able to get the British doctor is not making much money, except some few specialists. Driscoll continues:

"Now, such new drugs as aureomycin, one of the so-called miracle drugs, are needed by many millions of persons suffering from certain specified ailments. A relative of mine recently took the aureomycin treatment, lasting two days. He paid $16 for having the doctor's prescription filled, besides paying the doctor $10 for prescribing it.

"In England, at that same minute, the same prescription was being filled at the price fixed by law, 14 cents. Prior to the recent "austerity" laws and devaluation of the pound, the English patient was getting the prescription filled free of charge."

"Few Americans can afford $16 for a dozen pills. So the American who needs medical and surgical care and drugs is apt to say, 'Well, we're spending our money to buy these things for the English, who mock us for our generosity; why not do as much for the Americans, who pay the bills?'

"There is some practical logic in that, but it doesn't mean that state medicine, creating a vast new bureaucracy, with all its votes going for lifetime jobs for the Washington politicians, is a good or desirable thing."

PROPOSAL TO CURB FREE MEDICAL AID

WASHINGTON, Nov. 18—(AP)—The budget bureau has proposed that the armed services stop providing free medical and cut-rate hospital care for families of service personnel living in this country.

Budget Director Frank Pace wrote Secretary of Defense Johnson that such services could be halted now in view of the $330,000,000-a-year pay raise recently granted to members of the armed forces.

That raise, he said, lifted military pay to "levels commensurate with pay" of federal civilian employes who do not receive such medical, dental and hospital care.

Would Ease Shortage

Pace also said that elimination of the services would cut military costs and help ease the shortage of doctors and dentists in the army, navy and Air Force.

His letter was merely a proposal, rather than an order. If the armed forces oppose it, the matter presumably would be turned over to President Truman for a decision.

Johnson was reported today to have referred Pace's letter to the defense department's personnel policy board for study. Some members of the board, in the past, have expressed belief that military morale would be hurt if the medical service to dependents is discontinued.

The Hoover commission last summer estimated that about 900,000 dependents of the army and Air Force alone are receiving or are eligible for substantially free medical care.

Move for Reduction

The commission suggested that congress say what beneficiaries should receive medical care as a move to reduce hospitalization costs. It described free medical care as actually a part of the pay and emoluments received by members of the armed forces and said this factor should be considered in any action by congress.

In addition to free attention by military doctors, dependents of service personnel can get hospitalization for about $1.75 a day. The armed forces estimate that it costs as high as $13 a day to operate a hospital room.

Under Pace's plan, the discontinuance of the services would affect only military dependents within the United States.

Even then, Pace told Johnson, there should be an exception for service families stationed in areas where private facilities are insufficient to provide the care.

However, in such cases, he proposed that military services charge the full cost they incur in providing the service.

He also specified that service should be provided "on a humanitarian basis in event of emergency."—*The Enquirer and News,* Battle Creek, November 18, 1949.

(Continued on Page 42)

(Continued from Page 40)

FREE MEDICAL CARE MAY END FOR THOUSANDS

Several thousand dependents of service men residing in the Battle Creek area would be affected if Defense Secretary Johnson should follow the recent budget director's recommendation and discontinue providing medical and hospital services.

It has been the policy of the army medical service to provide care to dependents of service men whenever and wherever such care is available.

Percy Jones General hospital provides such services to the families of soldiers, sailors, marines and air force personnel residing in Battle Creek and vicinity, and also provides hospitalization at times for members of families living in nearby states.

No dental services are provided to dependents in this area, because of shortage of army dentists.

The Battle Creek area, with the reactivation of Fort Custer, will have one of the largest concentrations of military families in the midwest. It is estimated that nearly 3,000 dependents live in Battle Creek and vicinity.

Should they be cut off from care by army physicians, it undoubtedly would throw a tremendous burden on the civilian physicians.—*The Enquirer and News,* Battle Creek, November 18, 1949.

THE POLITICIAN'S PARADISE*

MR. FORD: Mr. Speaker, under leave to extend my remarks in the *Record,* I include the following poem by Mrs. R. Earle Smith:

THE POLITICIAN'S PARADISE

To socialize doctors, politicians would try—
A dictator's paradise, no one can deny.
Good honest medicine they would efface,
A political nostrum, instead to replace.

The totalitarian talk is only for the majority,
They think it's unimportant—to protect the minority;
If this trend of thought is not quickly curbed
All private enterprise will soon be disturbed.

The bureaucrats, socialism would spread,
Such a state of affairs is something to dread;
If their propaganda the public should heed—
To communism this eventually will lead.

We always look to our country with pride;
For our democracy, men have fought and died
Free enterprise is part of their contribution;
Any kind of dictatorship is against the Constitution.

The demagogues' talk is so full of deception—
What they mean, the public has no conception;
These bills they promote—greatly increase the tax,
To mention the truth, agitators are lax.

Thousands of employes will have to be hired,
To handle the red tape and taxes required.
The things they claim to the people are free
A national burden, ultimately will be.

Political medicine fails wherever it is tried;
The best medical care—patients are denied.
American medicine is the best in any land;
This truth the layman must understand.

If honest facts the proponents do not hide,
Each man for himself can then decide
And the black flag of absolutism will never wave
O'er the land of the free and the home of the brave.

MRS. R. EARLE SMITH.

*Extension of Remarks of Hon. Gerald R. Ford, Jr., of Michigan in the House of Representatives, Monday, April 11, 1949.

MR. AND MRS. PUBLIC

If the Socialized Medicine Bill should pass
  You will groan, sigh and say "Alas"
We did not give this bill attention
  It couldn't have passed with our intervention."
I'll relate to you what will happen right here—
  Your doctor, whom to you is dear,
From your family life will soon disappear.
  When you are sick you will realize
There will be no more private enterprise!
  To pay expenses when you are ill,
Your taxes increase to foot the bill.
  A slice of your pay each week will be taken—
You'll have much less when you bring home the bacon!

Now say to yourself "Which shall it be:
  Dictatorship, or my choice of doctors for me?"
We pay tribute to Uncle Sam,
  His name we will always shield;
If they change him to Uncle Sam, M.D.,
  He will surely be in the wrong field.
So—study this bill and a little time spend
  On deciding just what you should do;
When you learn the truth, against it contend
  Or the day that it's passed you will rue!

To your Senators and Representatives please drop a line
Requesting them, this bill to decline.

MRS. R. EARLE SMITH

The Detroit Regional Committee on Trauma, American College of Surgeons, will hold a Symposium on Trauma on Wednesday, March 8, 1950, in the English Room of the Book-Cadillac Hotel, Detroit, from 3:00 to 5:00 p.m. All MSMS members are cordially invited to attend. Program will be published in the February number *JMSMS.*

* * *

R. S. Sykes, D.D.S., Muir, Michigan, is the sponsor of the annual Sykes Lecture, presented on the occasion of the Michigan Postgraduate Clinical Institute. The Sykes Lecture this year will be presented on Thursday, March 9, in the Grand Ballroom of the Book-Cadillac Hotel, Detroit. Plinn F. Morse, M.D., Detroit, the 1950 Lecturer, will speak on "Laboratory Methods for the Diagnosis of Malignancy."

* * *

Mount Carmel Mercy Hospital, Detroit, celebrated its Eleventh Annual Clinic Day on January 25. Speakers included Saul Rosenzweig, M.D., Detroit; Carl P. Huber, M.D., Indianapolis; N. Chandler Foot, M.D., New York; Richard B. Cattell, M.D., Boston; Thomas Francis, Jr., M.D., Ann Arbor; Hans Selye, M.D., Montreal; George Crile, M.D., Cleveland. The luncheon speaker was Preston Slosson, Professor of History, University of Michigan. The Clinic Day was followed by a dinner-dance at the Book-Cadillac Hotel with Bishop Charles Leo Nelligan of Windsor speaking on "The Past Half Century."

Editorial Comment

SENSE ON HEALTH

There's nothming more devastating to a theory than a few facts. The truth of this old saw is demonstrated anew by Columbia University's study of the hospitals of New York state, recently completed after fifteen months' investigation under a state grant of $60,000. The Columbia document collides head on with most of the assumptions underlying the recent agitation for "socialized medicine" or for national compulsory medical insurance. It proved that for at least one great state of 14.5 million (10 per cent of the U. S. population) American medical service is in pretty good shape.

The argument for a comprehensive federal subsidy of medicine makes much of the alleged fact that private, municipal and state-owned hospitals, squeezed by rising costs, cannot be locally supported cornerstones of an effective medical system. But the Columbia study suggests the precise opposite. Far from operating in the red, the New York hospital system, both public and private, is found to be in constantly improving financial condition—better, in fact, than at any time since 1940. The most pressing need for general hospitals disclosed by the survey is not for additional facilities but for improving the diagnostic services and for modernizing or replacing old buildings that are becoming obsolete. Additional state aid for care of mental and tuberculosis patients is also needed.

It undoubtedly will be urged that findings for New York State are not applicable to the U. S. as a whole. Dr. Eli Ginzberg of Columbia's Graduate School of Business, who directed the survey and put its findings into a book. *A Pattern for Hospital Care,* thinks otherwise. New York is admittedly richer than most states in the union, and its ratio of doctor and bed capacity per capita is at the top. But Dr. Ginzberg, who received buttressing material from thirty other states in the course of making the New York survey, believes that his findings have great relevance to a majority of the states. What New Work can do, other states can do. Certainly on Dr. Ginzberg's showing states like Pennsylvania, Massachusetts, Illinois, Ohio and California with rich and large centers of population can aspire to New York's record.

The most astounding statistic turned up by the Columbia survey is that 57 per cent of the New York State population was covered by some type of voluntary hospital insurance at the end of 1948 —and the figure has kept growing throughout 1949. Eventually, Dr. Ginzberg thinks some 85 per cent of the New York population could be enrolled in Blue Cross or commercial voluntary insurance plans. If the 85 per cent figure can be approximated in the more populous states, then the case for national compulsory medical insurance must fall flat. Limited federal aid for specified purposes in sub-par areas is demonstrably necessary. But this is a far cry from total federalization of U. S. health services.—Reprinted by permission, from *LIFE*, December 5, 1949. Copyright, *TIME*, Inc.

AS WE SEE IT

Federal Security Administrator Oscar Ewing recently spent a week in England, "studying" the Labor Government's system of national medicine, which he hopes to duplicate in the United States.

Ewing had hardly gotten off the boat before he told a press conference that Britain's socialized medicine "was working remarkably well," and "exposed" an American medical group which had sent funds to "diehard" British doctors with which to fight state medicine.

The British medical profession, however, had the last word. The "diehards," otherwise the British Fellowship for Freedom in Medicine, sharply challenged the truth of Ewing's statements on all counts. The American funds received were infinitesimal, amounting to about $500; membership of the British Fellowship comprises more than 10 per cent of the practitioners in Great Britain, and Ewing was accused either of deliberately lying or not having the faintest conception of what he was talking about.

Of course, Ewing's statements were really for American, rather than British consumption. They merely followed his technique of distortion by which he hopes to socialize America, starting with medicine.

That's not a prescription which the American people want. They prefer the truth about such a controversial issue, sans emotion of the Ewing kind. Moreover, they want full, adequate medical care; not the impersonal socialized panacea of the type of which our own Receiving Hospital recently gave us an example when it left an injured man, unattended in the corridors, to die from lack of attention.—Editorial, *Detroit Free Press,* December 14, 1949.

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 49 JANUARY, 1950 NUMBER 1

President's Address

By E. F. Sladek, M.D.
Traverse City, Michigan

THE PAST YEAR has been marked by outstanding discoveries and accomplishments in the field of medicine and surgery—new instruments, techniques, and drugs to help fight and conquer illness. However, it also has been marked by another quite different but significant action. Our doctors of medicine have stepped down from their ivory towers and removed their cloaks of scientific isolation. They have suddenly realized that, in addition to being doctors, they are also citizens, and as such, believing in a free America, they have to become torch bearers for private enterprise.

For a number of years a few officers and committees of organized medicine were cognizant of the trends to the left on a national level. Almost alone they performed a yeoman service in fighting off socialized medicine. Most of our doctors did not then fully realize the real social implications of legislation such as the Wagner-Murray-Dingell bills repeatedly introduced in Congress.

The dramatic announcement of President Truman, following his election, stating, by implication, his determination to establish the welfare state, with a national compulsory sickness insurance plan as a primary requisite, awakened the nation to impending danger.

The medical profession, finding itself the target of the attack, became thoroughly aroused and determined to do something about it. From intensive studies of past and present legislative proposals in the field of health, doctors across the nation concluded that, among other things, the social planners were using the catastrophe of sickness as a stepping stone to the socialized state. An analysis of legislative bills showed that government could not, and would not, guarantee definite set medical services, nor could they estimate or predict the actual costs of these services. They were asking the public to give them a blank check to cover, by taxation, these undetermined costs. In return for this, they would set up rules, regulations, and directives to determine *forever* the way you, as a citizen, would get medical care, the kind you would get, and from whom you would get it. The medical profession would in turn be told whom to treat, the type of medical and surgical treatment we could administer, and for how long a period. What does this add up to? Dictation for you and for us. Like you, we don't like it.

History has proven that once government gains control of sickness and health of its people, it is very easy to expand to the eventual control of all professions, of all businesses, of all industries, and of all occupations. This fight to prevent the establishment of the socialized state is not that of the medical profession alone, but one that involves *all* our people. The sad fact remains that we, as individual citizens, have no official vote as to whether or not we want socialized medicine and the welfare state. In modern politics, that is the task of our lawmakers. But in this republic we do have one recourse, and that is to tell our own legislative representatives how we feel about this proposal. They still heed the majority opinion.

The medical profession, through the American Medical Association, has been accused of developing the most powerful and richest lobby ever to confront Washington. We have been accused of extreme selfish interest—because, by a voluntary as-

Presented during Officer's Night at the eighty-fourth annual session of the Michigan State Medical Society, Grand Rapids, Michigan, September 21, 1949.

sessment we have developed a fund of about three million dollars, which we are using to educate the American people as to what modern medicine is, and does, and offers by voluntary action. Our critics conveniently forgot to mention the seventy-five millions available to the Federal Security Administration specifically for so-called "educational" purposes, and that this huge fund is being used principally to advance the cause of socialized medicine and the welfare state.

The past two decades have witnessed a tremendous change in American medicine. Our medical schools have greatly increased their educational standards and the caliber of their teaching staffs. They have instituted a markedly expanded curricula, and established research projects resulting in new and finer medical and surgical techniques. Greater efficiency in the appurtenances of medical practice has been developed. Together with organized medicine, intramural and extramural courses have been established for the continued postgraduate medical education of our practicing doctors. All this has resulted in the highest type of medical personnel and medical procedures for the American citizen. May I repeat, this has been for the American citizen—and by *voluntary* action.

Organized medicine has insisted on high standards for specialized medical services, has instituted residency training in the specialties, and boards for examination and certification in these specialties. It has developed societies and groups of doctors interested in special or specific diseases, thus making available to the public a superior type of consultive service when necessary.

Many community organizations and groups have projects relating to health. Our doctors are active in them and give unstintingly their time, scientific knowledge, and personal assistance to help solve both health and community problems. The great public good done by these organizations is due in a large measure to this voluntary co-operation of the doctors. They work hard to promote and achieve success for the Michigan Health Council, the Rural Health Conferences, polio, tuberculosis, cancer, heart, crippled children, rheumatic fever, and a host of other campaigns in the health field. Truly the doctor is also the citizen and recognizes his duties as a citizen.

Organized medicine is cognizant of the fact that social service is a definite part of medical service. They know that modern medical practice is not perfect and does not serve all of our people to the best advantage, and that illness can be a financial disaster to the patient. To help solve this, the medical profession proposed, developed, and implemented our voluntary, nonprofit, prepayment, medical, surgical, and hospitalization plan. I am proud to say that our own Michigan State Medical Society was a pioneer in this endeavor. Beyond any question of doubt, the success of these plans is giving a highly satisfactory service to our people. They are truly American, administered in the American way, for Americans.

We realize that these plans are not perfect, nor as completely adequate as desired. However, through intensive study of economic and social conditions, and by actual experience, they are being rapidly broadened and amplified to include and cover more and more of the financial hurdles of illness. In addition, they already have stood the test of time, and we have definite knowledge as to basic costs—not theoretical, but factual. This knowledge is being put to use immediately, as evidenced by the recommended expansion at this annual meeting of the Michigan Medical Service to serve new income groups—a higher income group than has ever been covered previously by any prepaid medical service plan. The ideal of a medical service plan is to offer *complete* coverage. We will have gained that objective in this new proposed policy.

Do you think that these objectives and accomplishments denote selfish interests? Are we self-seeking when we bring to the attention of our patients and neighbors facts and figures on illness and health, which, surely, we doctors of medicine know more about than do the politicians? Are we employing power politics when we attempt to inform our legislative representatives that we know that the great majority of our people do not want socialized medicine and the welfare state? Surely, if America is to remain a country of free enterprise—a country of the people and for the people —then it is the people, in addition to the doctors, who must think and act.

The campaign of the American Medical Association, ably assisted by the Michigan State Medical Society, has been eminently successful to this date. Precipitate action has been postponed by Washington. We have been granted an opportunity to continue our educational campaign until next spring. As citizens, we cannot rest upon our laurels now, but must be ready with positive and

(Continued on Page 74)

Experiences with Routine Rh Typing in Obstetrics

Observations in a Series of 100 Rh Negative Pregnant Women

By Charles W. Aldridge, M.D., and
Robert M. Campbell, M.D.
Ann Arbor, Michigan

ALMOST TEN YEARS have elapsed since Landsteiner and Weiner[12] discovered the Rh factor and Levine[13] pointed out its relationship to transfusion reactions, erythroblastosis fetalis and congenital hemolytic anemia. During this time a wealth of laboratory work has been done, yielding a clearer understanding of the serologic, genetic, pathologic and anthropologic manifestations of this problem. There has, however, been a lag between the clinical application and the progress in the laboratory. The lack of men trained in the technique and theory of this field and the scarcity of typing sera are perhaps two of the several reasons for this. Some of these difficulties have now been overcome, and the way lies clear for a more widespread study of the Rh problem. Not until a large number of cases have been carefully observed, both clinically and by the laboratory methods available, will correlation of knowledge be possible and improvement of antepartum and postpartum treatment follow.

More and more the Rh type is becoming an important part of our routine initial "work-up" of any patient. It is especially important in the obstetrical patient. During the last year, the services of the Michigan Department of Health Laboratory have been made available for Rh determinations at no cost to the patient, and in most cases antibody determinations will be done on request. This indeed is a step toward focusing more widespread clinical attention on this problem.

Incidence of Rh Incompatibility and Sensitization

Genetically speaking, since the Rh-negative trait is recessive, the true Rh-negative individual must be homozygous, and the genotype must be expressed by the symbol "rh rh" (rr-Weiner[23] cde-Fisher and Race[7]). The red blood cells of these individuals will not agglutinate with any of the three anti-Rh serums (anti-Rh′ anti-Rh," anti-Rh°). They make up 13 per cent of the general population (Caucasians). The rest of the population are Rh positive inasmuch as their red blood cells will agglutinate (at 37°C.) with at least one of the three anti-Rh serums. Since the Rh-positive trait is dominant, however, these persons may either be heterozygous (Rh rh) or homozygous (Rh Rh). General population figures quoted by Sacks[19] show that 41 per cent are homozygous (Rh Rh) while 46 per cent are heterozygous (Rh rh).

From the above information, as expressed in Figure 1, one can predict much about the occurrance of Rh incompatibility: 11.3 per cent of all matings will be between Rh-negative women and Rh-positive men. Of these 11.3 per cent, 5.3 per cent will be with homozygous men, and 5.98 per cent will be with heterozygous men. One-half of the children from matings with heterozygous men will be Rh negative and one-half will be Rh positive. Of all children born of Rh-negative mothers 8.32 per cent will be Rh positive. In only these 8.32 per cent, then, will the opportunity for sensitization to the Rh factor exist.

When the opportunity exists, however, sensitization does not always occur. Sacks[19] has reported less than 10 per cent of the expected incidence of sensitization in all pregnancies. Only 5.26 per cent of all Rh-negative female—Rh-positive male matings showed evidence of sensitization. The opportunity for sensitization in such matings occurs in 73 per cent. Conversely, sensitization is also not observed in all cases of erythroblastosis. The absence of antibodies in the presence of erythroblastosis fetalis has been observed by various authors[19,21] in about 10 per cent of all cases of erythroblastosis. The discrepancy between the theoretical and observed figures has been attributed to: (1) the infrequency of evidence of erythroblastosis fetalis in first pregnancies in the absence of previous transfusion or blood injection, (2) variation in placenta permeability to fetal red blood cells, (3) variation in maternal response to antigenic stimulation, (4) failure to find other antigens and antibodies such as Hr, A, B, M, and Rh subtypes because of scarcity of sera and weakness of serologic response.

In addition, it appears that even after sensitization develops, as evidenced by appearance of antibodies in the mother's serum during pregnancy, the

From the Department of Obstetrics and Gynecology, University of Michigan Hospital, Ann Arbor, Michigan.

infant is not doomed to show clinical or even subclinical evidence of erythroblastosis fetalis. Sacks[19] reports that 67.19 per cent of the children of sensitized Rh-negative mothers which he observed —Rh-negative female matings which develops erythroblastosis in the absence of sensitization, only 5.26 per cent became sensitized. This cuts our incidence down to .45 per cent of all matings. Then,

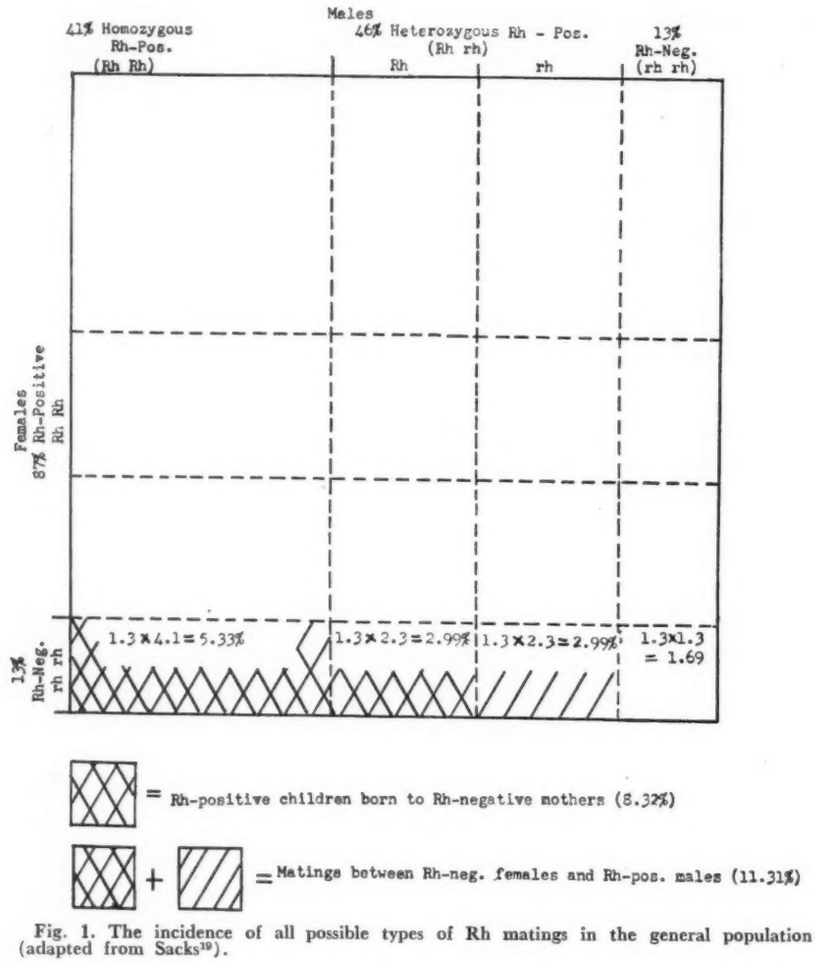


Fig. 1. The incidence of all possible types of Rh matings in the general population (adapted from Sacks[19]).

had varying manifestations of erythroblastosis fetalis. This difference, he states, is due to (1) failure of antibody to reach a high enough level to produce disease in the infant, or (2) delivery of an Rh-negative infant in a mother whose antibody was formed as a result of previous stimulation. As will be pointed out later, others feel that the type of antibody, the titer of antibody, and the duration of exposure to antibody also play a role in the production of erythroblastosis fetalis.

Consider then the chances of any women having an infant showing manifestations of erythroblastosis. First she must be one of the 13 per cent which are Rh negative. She then must qualify by having an Rh positive child. This incidence, as we have pointed out, is 8.32 per cent. Excluding the small group (10 per cent) in all Rh-positive male in this group of sensitized individuals, if we accept Sacks figure of 67.1 per cent of these which show erythroblastosis, we end up with .30 per cent of all matings that will show erythroblastosis fetalis. This agrees with the observed incidence as quoted by Weiner[22] to be one in 300 of all deliveries (.33 per cent). Actually Rh-negative women have about a 2.3 per cent chance of having children which show evidence of erythroblastosis fetalis. Of course, all fetal disease due to Rh sensitization will not be fatal.

The general public has been copiously educated regarding the Rh factor. It seems, however, that most such reports have been over-alarming. Physicians are well acquainted with the panic often observed when a patient is first informed she is "Rh negative." Lay fear of the Rh problem could

be partly dispelled by clarification of the factors influencing the incidence of erythroblastosis fetalis and by pointing out the effectiveness of treatment in the less severe cases.

Relations of Rh Isoimmunization to Parity, Abortion and Stillbirth

Parity.—Isoimmunization does not occur in first pregnancies if there has been no pre-existing sensitization. With each succeeding pregnancy sensitization and evidence of erythroblastosis is more likely to occur. If erythroblastosis is mild in one pregnancy, subsequent pregnancies will yield more serious manifestations of the disease, including hydrops and stillbirth.

The above is a usual description of the relationship between parity and isoimmunization. In any one case, however, one may find considerable variation from this general trend. Coombs[3] reports that only six out of ten primigravida with antibodies gave a history of previous transfusion. Howard[8] found antibodies in twelve of forty-eight primigravida, one of which had an erythroblastotic infant. Spalding[20] also describes a first pregnancy which resulted in a macerated hydropic fetus, in which after careful questioning there was no history of previous blood transfusion or injection and in which the agglutinating antibody titer was 1:64. On the other hand, Abt as quoted by Darrow[4] has seen an infant with familial jaundice of the newborn which recovered after several siblings had died of icterus gravis. It seems then, that antibodies can and do develop in primigravida, and also that sensitized multipara are not doomed to repeatedly produce children with increasing evidence of erythroblastosis.

These variations in occurrence of pathological manifestations of Rh isoimmunization are, at least in part, explainable by our present knowledge of the pathogenesis of this disease. If the father is heterozygous, a woman may become sensitized by several Rh-positive children and then have an Rh-negative child which will not cause further sensitization nor be affected by antibodies produced by previous pregnancies. Erythroblastosis fetalis may be produced by the less frequently occurring Rh types (Rh,′ Rh," Rh′Rh," Rh_0, Rh_1, Rh_2, Rh_1 Rh_2—Weiner). The antigenic properties of these types are less than the more common Rh antigen (rh) and the disease produced by sensitization to them is rarer and milder. However, an individual may be Rh positive by tests with the most common anti-Rh (Rh_0) serum and still deliver an erythroblastotic infant due to Rh sub-type sensitization. Similarly several erythroblastotic infants may be produced in one family due to sub-type isoimmunization, and then a normal infant be delivered when the fetal sub-type agrees with the maternal sub-type due to fraternal heterozygosity.

These experiences of others tend to strengthen our view that, at present, sterilization of a patient who has had several infants die of erythroblastosis fetalis is not indicated. It seems evident that the serologic and antibody tests now available to us do not give us a clear enough picture of any one family's serologic make-up to be dogmatic enough to recommend such an irreversible procedure.

Abortion and Stillbirth.—At first there was general agreement among most investigators that no relationship between the Rh factor and abortion could be demonstrated by the tests then available. In 1942 Javert[10] said, "Unless additional evidence shows the contrary, early habitual abortion should not be attributed to isoimmunization." With the development of more sensitive tests, however, the question of the significance of Rh isoimmunization has again been raised.

Sacks[19] and Levine[15] have found a higher incidence of spontaneous abortion in Rh-negative sensitized women and believe that further investigation is necessary. On the other hand, Overstreet[16] has found very little difference in the total abortion rate of Rh-negative and Rh-positive women. He also does not find a greater abortion rate in Rh-negative mothers with one child having manifested evidence of hemolytic disease. Hunt's study[9] also supports these findings.

Hunt[9] has presented a theoretical explanation of why Rh-isoimmunization is not a factor in the etiology of early abortion. He points to work of Page, Hunt and Lucia[17] which indicates that antibodies must be produced for a period of about ten weeks before fetal damage occurs. By analogous reasoning from the time of appearance of fetal B-agglutinogen[1] he proposed that the earliest possible production of Rh-antigen should be the second to fourth week of pregnancy. If this is true, then of course isoimmunization is impossible before that time. By further assuming "that several weeks more than the ten weeks period might be required to produce damage extensive enough to result in

expulsion of the pregnancy, then the summation of the time factors alone would be in the neighborhod of twenty weeks, the onset of viability."

To demonstrate the agglutinating or bivalent antibody, a 2 per cent saline suspension of type O Rh-positive cells is tested against an unknown

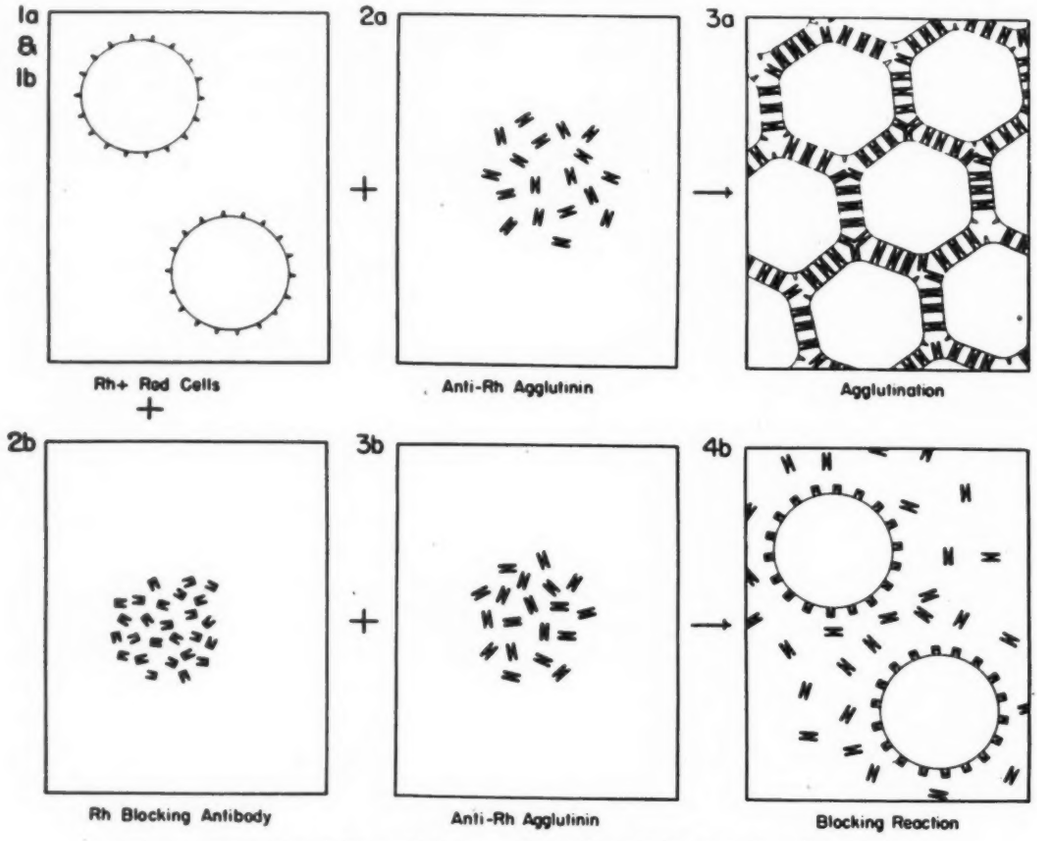


Fig. 2. Comparison of Rh agglutination and blocking reaction (tests in saline media).

Clearly the above discussion of Rh-isoimmunization and early abortion cannot be applied to a similar discussion of the relationship of Rh to neonatal death and stillbirth. These conditions are known to be caused by the presence of maternal Rh antibody in the fetal circulation. Hunt[9] found a neonatal death and stillbirth rate of 6.4 per cent in Rh-negative women compared to 1.5 per cent for Rh-positive women. Undoubtedly the major portion of the 6.4 per cent were more severe forms of erythroblastosis, including hydrops and icterus gravis.

Importance of Antibody Determinations

Until 1944, more than one-half of all pregnancies resulting in erythroblastosis fetalis lacked demonstrable antibodies. Since the blocking antibody was found by Race,[18] Weiner[22] and Diamond,[6] almost 100 per cent of all cases show antibody at some time during the antepartum or postpartum period.

serum at 37°C. Clumping indicates the presence of agglutinating antibodies. Weiner describes the mechanism of this reaction as follows: "The surface of the erythrocytes can be visualized as being covered with hundreds of thousands of hapten groups. The agglutinins on the other hand are modified gama globulins and behave as if they possess two or more specific combining groups. When a blood suspension and agglutinins are mixed, each molecule or antibody links two red cells together and clumping occurs by the formation of a lattice work" (Fig. 2).

To demonstrate the blocking or univalent antibody, a 2 per cent suspension of O Rh-positive cells in AB serum or pooled plasma is used in a test with the patient's serum, as for the agglutinating antibody. If the test for agglutinating antibody is negative and clumping now occurs, the blocking antibody is present. The mechanism of this reaction can best be visualized if we consider the blocking antibody as having only one specific combining

group. When these cover the hapten groups of the erythrocytes, clumping cannot occur unless a third factor is present, which Weiner calls conglutinin or x-protein. Weiner states that "many proteins in concentrated solution form colloidal aggregates that can function as conglutinin." X-protein is rendered inactive by dilution in saline and therefore blocking antibody cannot be demonstrated in any but a non-aqueous solution (Fig. 3).

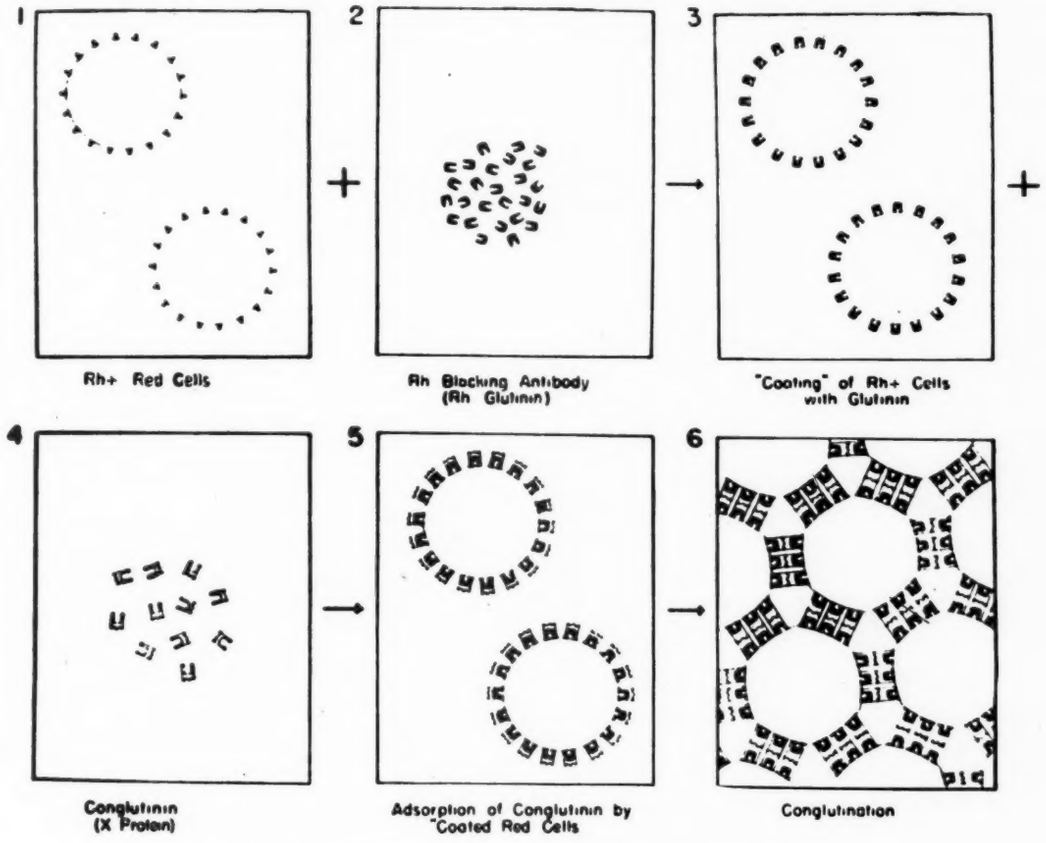


Fig. 3. Rh conglutination reaction (tests in plasma or serum media).

Weiner believes that most isoimmunization takes place during labor and delivery because contractions of the uterus at that time "milk" more fetal cells into the maternal circulation. Levine on the other hand feels that antibodies may develop at any time during pregnancy, especially during the last trimester.

Another recent concept proposed by Weiner[22,23] concerns the pathogenesis of erythroblastosis. It is his hypothesis that erythroblastosis fetalis consists of three distinct, though related, clinical diseases determined by qualitative differences in the abnormal maternal antibody. First under this heading comes icterus gravis neonatorum, which is primarily derived from isoimmunization by the agglutinating antibody. This antibody, being of larger molecular weight than the univalent antibody, passes through the placenta with greater difficulty and mostly at the time of labor. The second group, congenital hemolytic disease, is mainly the result of univalent or blocking antibody isoimmunization. These antibodies, being of smaller size, pass through the placenta more readily during pregnancy. The resulting fetal disease is not as severe as the first groups. The third group includes icterus precox, which is derived from A and B antibodies and is the mildest form of this group of diseases.

Other investigators believe that the study of antibodies will reveal more information of prognostic importance. Howard[8] found that a group of women who were delivered of infants with frank hemolytic disease showed less blocking antibody than agglutinating antibody before delivery, while a group of women who were delivered of infants with milder subclinical hemolytic disease showed a higher antepartum titer of blocking antibody than agglutinating antibody. A reciprocal relation-

ship between the blocking and agglutinating antibody was also observed, but he felt that no deductions should be made from this data. A protective action of blocking antibody has been suggested by many investigators, but as yet no definite conclusions can be made, mainly because it cannot be determined if the *in vitro* behavior and tests for the two antibodies are typical of the reactions *in vivo*.

Howard,[8] Sacks[19] and others have also observed a direct relation of the duration of exposure to antibody and the level of antibody titer to the seriousness of the resulting fetal pathology. Howard, however, believes that they have demonstrated that the duration of exposure to antibody is first in importance. Sacks and others disagree, feeling that duration of exposure to antibody is secondary to the strength or degree of isoimmunization, as reflected by the height of antibody titer.

As yet, there seems to be no general agreement in the interpretation of antibody findings. However, it does seem that this is indeed a fertile field for further investigation. The day may not be far off when it will be possible to predict the outcome of a pregnancy involving Rh-isoimmunization by study of antepartum antibody production.

Prevention of Rh-Isoimmunization and Treatment of Erythroblastosis Fetalis

Kariher[11] has pointed out that, theoretically, prevention of erythroblastosis fetalis during pregnancy could be accomplished by any of three different means: (1) prevention of the antigen-antibody reaction by chemical means, (2) absorption of antibody by Rh hapten injection, (3) inhibition of Rh antibody production by some immunological means.

Kariher[11] has presented a possible approach by the first method, mainly, by repeated injections of small doses of ethylene disulfonate. He reports three successful cases but leaves the matter to further clinical trial before making any conclusions.

Recently, the isolation of Rh haptens has been reported.[2] As yet there has been only limited clinical experience with them. However, this is indeed a promising field for further investigation.

Weiner[21] has approached the problem from immunological angles. He states that it is a general immunologic concept that if the two antigens are given simultaneously, the more potent one tends to suppress the antigenicty of the less potent one. In other words, the administration of some potent antigen such as diphtheria, pertussis or typhoid innoculations might suppress the reaction of the relatively weak Rh antigen. A few case reports have been published which apparently prove that this does occur.

Methods

During the twelve-month period from October, 1946, to October, 1947, there were 850 deliveries on the private and clinical services. Each patient who registered on the obstetrical service received as part of her routine laboratory examinations a blood type and Rh determination. An attempt was made to investigate the Rh type of the husbands of all Rh-negative women. If he was Rh positive, indicating an incompatability, blood was obtained from the woman at varying intervals during the last trimester. These specimens of serum were then tested for the presence of Rh hemagglutinins by two methods: (1) In the microscopic slide test,[10] the serum was mixed with the proper type of heparinized whole blood on a slide and agglutination read three to six minutes later. The slides were kept warm on the lid of a water bath adjusted to 37° C. (2) A further check on the occurrence of antibodies was made by sensitizing washed test cells with the woman's serum and mixing these cells with anti-human globulin rabbit serum according to the method of Coombs and Race.[3] When antibodies were demonstrated by the above tests the woman's serum was titrated by two-fold serial dilution in (1) a 2 per cent suspension of washed O Rh-positive cells in saline, giving the titer of agglutinating antibody; (2) A 2 per cent suspension of washed O Rh-positive cells in homologous adult serum, giving the titer of incomplete, conglutinating or blocking antibody. Agglutination or conglutination was read as the highest dilution of the serum giving grossly visible clumping.

Regardless of whether the mother had shown antibodies or not, all babies born to Rh-incompatible couples were followed carefully for evidence of developing erythroblastosis. Cord blood was obtained at delivery for typing and antibody studies as outlined above. The baby's hemoglobin and red blood cell count were determined immediately after birth and every four to six hours for the first twenty-four hours of the neo-natal period. If there was no abnormal drop in these values, repeat determinations were done twice the next day and then daily until the infant was discharged from the hospital on the tenth day. If there was

any suspicious fall in the cell count or hemoglobin, more frequent examinations were carried out as indicated. Likewise, the infant was closely watched for the appearance of any clinical sign of possible Rh difficulties. Following discharge from the hospital, the hemoglobin and red cell count were checked at varying intervals until after the six-week check-up examination.

We have routinely examined all placentas microscopically for evidence of erythroblastotic, anemic, or hydropic changes. Products of abortions, stillborn infants and neonatal deaths were similarly investigated. Thus, a review was made of any tissue specimens sent to the pathology department from the pregnant women involved in an Rh incompatibility.

An attempt was also made to determine any possible correlation between Rh incompatibility and abortion, stillbirth, or toxemia or pregnancy.

Results

Of the 850 deliveries during this twelve-month period, we had 100 women who were correctly typed as Rh negative. (There were twelve persons who were incorrectly typed Rh negative at first. The number incorrectly typed Rh positive is not known). The husbands of eighty-eight out of these 100 were typed, and seventy-nine were found to be Rh positive. Antibody determinations were done on seventy-six (95 per cent) of all our known Rh-incompatible couples, and were positive in three cases. The children of these three showed evidence of erythroblastosis. The cases are presented in order of increasing severity.

Case 1.—C. B., 596998, twenty-five-year-old white woman, para 2, gravida 3, type 0, Rh negative. Husband: type 0, Rh positive. First child had spinabifida; second child was normal. At the time of delivery of her third child, a 3-plus conglutination (blocking antibody) was demonstrated. The Diamond slide test showed 4-plus agglutination ten days postpartum and remained positive for more than one month. The infant was normal at birth with a hemoglobin of 21 grams (5.6 million red blood cells). The cord blood was type 0, Rh negative. There was no abnormal drop in hemoglobin or red blood cell count during the ten-day hospitalization after birth. At one month, however, mainly because the mother was showing antibodies, the baby was retyped and found to be 0, Rh positive. At this time, the baby's hemoglobin was 6.7 grams with erythrocyte count of 2.37 million. Several transfusions of Rh-negative blood were given, with prompt return of the hemoglobin and red blood cell count to normal. The baby survived with no further complications.

Case 2.—C. S., 515618, twenty-three-year-old white woman, para 1, gravida 1, type 0, Rh negative. Husband: type 0, Rh positive. This patient had been transfused with her husband's blood on one previous occasion without reaction. She had no antibodies at the end of her fifth month, but in the ninth month her Diamond slide became 3-plus with a 4-plus agglutination of cells suspended in anti-human globulin rabbit serum, indicating blocking antibodies. At birth, the baby was markedly jaundiced. The hemoglobin was 7.5 grams with red blood count of 1.41 million. In spite of transfusion the baby died shortly after birth. The baby was type 0, Rh positive. Autopsy revealed generalized icterus and erythroblastosis.

Case 3.—E. L., 620756, thirty-two-year-old white woman, para 2, gravida 3, type AB, Rh negative. Husband: type A, Rh positive. First pregnancy was uncomplicated. Second baby became severely jaundiced and was a congenital spastic, but lived. The Rh type of both children is unknown. Although it cannot be proved, sensitization probably occurred during the second pregnancy. During the third pregnancy, her serum showed a 2-plus agglutination on the Diamond slide test two and one-half weeks before delivery. Six weeks after delivery, she had a high blocking antibody titer but no agglutinating antibody. Because she developed pre-eclamptic toxemia at the end of her pregnancy, labor was induced and delivery of a large hydropic infant was accomplished by a destructive operation. At autopsy, the baby showed the typical pathologic changes of erythroblastosis, including splenomegaly and hepatomegaly.

Stillbirth occurred four times in our group of 100 Rh-negative patients. In only one of these were antibodies demonstrated (Case 3).

Only two clinically significant toxemias of pregnancy developed in our 100 Rh-negative patients. One of these showed antibodies (Case 3). The other had an associated abruptio placenta, and the husband's blood type and antibody studies were not done.

The placentas of the three women showing antibodies failed to reveal any changes characteristic of erythroblastosis. On the other hand, eight aborted placentas from Rh-negative women without antibodies showed some hydropic change in the chorionic villi. The placentas of five other abortions in our incompatible group were normal.

Autopsies performed on the four infant deaths in our incompatible group revealed evidence of erythroblastosis in two (Cases 2 and 3).

Discussion

An analysis of our series permits only a limited appraisal of the incidence of various Rh problems and complications. Although there are ramifica-

tions to this problem, many of which are not thoroughly understood, complications attributable to Rh incompatibility are relatively rare in any total series of obstetrical patients studied.

The incidence of Rh-negative women in our series is 11.8 per cent (100 out of 850). The incidence of Rh-negative men is 10.2 per cent. (Seven out of eighty-eight). These figures agree fairly closely with the general population (Caucasians) incidence of 13 per cent. They are somewhat less because of the small size of our group and the inclusion of both colored and white women in the study.

There were forty Rh-positive infants born to fifty-six Rh-incompatible couples in which infant typing was carried out. This is an incidence of 72 per cent compared to the theoretical of 73.6 per cent. It can be calculated that 64 per cent of all Rh-negative mothers (regardless of husband's type) should have had Rh-positive infants. However, since the Rh type of all infants was not obtained, we cannot determine accurately this incidence.

In our fifty-six completely studied cases, we had sixteen (twenty-eight per cent) Rh-negative infants, which compares favorably with the expected occurrence of 26.49 per cent.

We found that 89 per cent of our Rh-negative women were mated with Rh-positive men. The general population figure is 87 per cent.

It can be determined that 73.6 per cent of all Rh-negative women mated to Rh-positive men will bear Rh-positive infants and therefore the opportunity for sensitization exists. As Sacks[19] has pointed out, however, actually only 5.26 per cent of all Rh-negative women mated with Rh-positive men show sensitization. Possible reasons for this have been outlined. Thus, although 73 per cent of our known seventy-nine Rh-incompatible couples with antibody studies had an opportunity for sensitization, only 5.2 per cent should have actually shown antibodies. Our three cases showing antibodies then is somewhat less than the expected incidence.

As Sacks[19] has further pointed out, evidence of erythroblastosis is observed in only 67 per cent of all Rh-negative sensitized mothers. We observed evidence of erythroblastosis in 100 per cent of our sensitized mothers in this series. Since the completion of this series, however, we have also confirmed the fact that sensitization does occur without evidence of erythroblastosis, and that erythroblastosis occurs without demonstrable sensitization. We, therefore, observe all babies from Rh-incompatible couples regardless of whether antibodies are present or absent. Type O, Rh-negative blood should be available at delivery of any Rh-negative woman.

All except one of our cases developing antibodies were multiparas. Our primipara bearing a hydropic infant had a history of previous transfusion with known Rh-positive blood. This emphasized the importance of testing for sensitization during first pregnancies.

Fifteen per cent of our Rh-negative women had one or more abortions. This is probably not above the total abortion rate in Rh-positive women. The possible necessity for re-evaluation of this problem has been pointed out.

Hunt's finding of 6.4 per cent stillbirth rate in Rh-negative women and an incidence of 4 per cent in our series logically indicates that this rate is higher in Rh-negative women.

The occurrence of two toxemias of pregnancy (pre-eclampsia) in our 100 Rh-negative women is probably not higher than one would expect in a similar unselected group.

Although all three babies were affected in the cases which demonstrated antepartum antibodies, the placenta in only one showed hydropic changes. However, some degree of hydropic changes were observed in the placentas of fourteen abortions in Rh-positive incompatible couples. We can draw no conclusions as to the relationship between Rh and placental pathology from this.

Summary

1. A brief review of the literature has been made with an attempt to develop the recent concepts of the Rh problem.

2. An analysis of a series of 100 Rh-negative pregnant women is presented.

We wish to acknowledge the contribution of Mrs. Delores Morriss and Dr. J. V. Quilligan, Jr., of the Department of Pediatrics Laboratory, who are responsible for doing the antibody determinations in addition to their many other duties.

References

1. Bornstein, S., and Israel, M.: Agglutinogens in fetal erythrocytes. Proc. Soc. Exper. Biol. & Med., 49:718, (April) 1942.
2. Carter, B. B.: Rh hapten, its preparation, assay, and nature. J. Immunol., 61:79-88, (March) 1949.
3. Coombs, R. R. A.; Mourant, A. E., and Race, R. R.: The detection of weak and "incomplete" Rh agglutinins. Brit. J. Exper. Path., 26:255, 1945.
4. Darrow, R. R.: Treatment of erythroblastosis fetalis. J.A.M.A., 127:1146, (April) 1945.

(Continued on Page 78)

Extra-abdominal Causes Producing Acute Abdominal Signs

By Russell Barnes, M.D.
Lansing, Michigan

IN AN ATTEMPT to diagnose an acute surgical emergency residing in the abdomen, accompanied by pain, many disturbances other than those causing acute surgical emergencies must be ruled out—a task which, by virtue of the pain the nonsurgical etiologic agents produce, may become quite perplexing to the examiner and of life-importance to the sufferer. An attempt will be made in this paper to discuss rather briefly some varied and common disturbances leading to acute abdominal pain of nonsurgical import. In the beginning it is of interest to note that Edmund van Neusser[12] states that "the history of the case should give us our correct diagnosis; the physical examination and laboratory tests should be merely confirmatory." Further, Zachary Cope[17] states, "The general rule can be laid down that the majority of severe abdominal pains which ensue in patients who have been previously fairly well, and which last as long as six hours, are caused by conditions of surgical import." This is further emphasized by the statement that a "persistent abdominal pain associated with nausea and vomiting and interference with bowel action, lasting more than six hours, usually requires surgical intervention."[20]

Briefly, the nervous mechanism for the production of pain shall be considered due to its importance in the differential diagnosis of many causes of abdominal pain.

Pain from the viscera is conducted from the nerve endings through the sympathetic fibers to the spinal tract. That this is true has been shown by the fact that sectioning of these nerves is followed by a relief of pain. In the somatic nerves a special portion of the nerve conducts pain. Somatic nerves have been shown to contain three types of nerve fibers designated A, B, and C fibers, each type physiologically different from the other. The A fibers range from 20 to 1 micron in diameter, with a conduction speed of from 120 to 5 meters per second; the B fibers are less than 3 micra in diameter and have a conduction velocity of from 15 to 3 meters per second; and the C fibers are unmyelinated, with a conduction speed of from 2 to 0.6 meters per second. In the presence of asphyxia the fibers are susceptible in the following order: B, A, and C. The A fibers constitute the somatic efferent and the B and C the somatic afferent and sympathetics. In the spinal cord the posterior root fibers conveying pain cross and form two tracts: the ventral and dorsal spinothalamic tracts. These tracts may be divided (chordotomy) in cases of intractable pain due to inoperable malignancies, with a relief of pain. From the thalamus, ipsilateral thalamocortical projections synapse and terminate in the postcentral gyrus, the cortical area of pain representation. Pain may be relieved then, by sympathectomy, rhizotomy, cordotomy, or subduing the cortical area of representation. Pain may be referred to an area from which it did not arise due to the anatomical relations; it is referred to the dermatomes supplied by the posterior roots through which the visceral afferent pain impulses have reached the cord.

Visceral pain differs from somatic pain in character, being dull, indefinite, gnawing, boring, and constant. It may be due to dilatation or distention of a hollow viscus, spasms of smooth muscles or vigorous contractions in the presence of ischemia, or due to chemical irritants. Somatic pain characteristically is sharp, shooting, stabbing, lancinating, and easily localized. So often, however, the case occurs in which these characteristics tend to merge, adding complexity to the type differentiation. This merger could be explained by the theory of Mackenzie[34] of the nervous mechanism of visceral pain which proposes that true visceral pain does not occur, but rather impulses arising in diseased viscera pass via the sympathetics to the cord to establish an irritable focus with an overflow of impulses into the specialized somatic pathways. With true visceral pain, abdominal tenderness and rigidity do not occur, this happening only when the parietal peritoneum is irritated causing impulses which are conveyed through the somatic nerves.[35]

Of the extra-abdominal causes of abdominal pain, diseases of the heart and cardiovascular system should be considered. Epigastric pain *per se* cannot be regarded as a criterion of diagnosis[28] of diseases of the abdomen. Congestive heart failure, hypertension, pericarditis, aortic aneurysm, cardiac irregularities, myocardial infarction and periarteritis are conditions which have produced

epigastric pain.[4] It has been noted that the abdominal muscles are never in great rigidity in cardiac diseases.[5]

Myocardial infarction has in recent years been associated with epigastric pain with increasing frequency.[6,8,13,16,42] Persons dying of myocardial infarction and abdominal pain have ofttimes been diagnosed as death due to acute indigestion. Many such cases reveal the history that sometime before the infarction occurs, the patient has eaten large meals. The fact that he has eaten leads such unsuspecting physicians to diagnose the cause of death as "acute indigestion." Fortunately, in recent years this has not been as frequent as previously, in that many physicians now associate abdominal pain with that of myocardial infarction.

The first symptoms to appear are usually nausea and vomiting, followed by epigastric fullness, anorexia, and gaseous eructations. In such cases it would be wise to inquire as to previous cardiac symptoms such as dyspnea, cyanosis, edema, or substernal discomfort. Conversely, it is well recognized that gall-bladder disease can simulate coronary artery insufficiency in producing symptoms. Again it would be quite helpful to obtain a history of previous chills and fever, jaundice, clay-colored stools, changes in urine color, the radiation of the pain, and the effect nitrites have upon the pain. Pain in the precordium may be produced in persons, particularly past sixty, by distention of the stomach. Such a case of confusion is reported by Stanley Camp.[13] Myocardial infarction of such magnitude may be easily diagnosed if one remembers the changes which occur and the time interval in which they occur in relation to the pain, temperature, white blood count, erythrocyte sedimentation rate, blood pressure, and the electrocardiogram in the presence of a friction rub.

Congestive heart failure may produce symptoms referable to the gastrointestinal tract, notoriously those symptoms of nausea and vomiting. McMillan[33] states the most common causes for such symptoms in congestive failure are due to "drugs, visceral congestion, vitamin deficiencies, stimulation of the vomiting center by metabolites such as seen in uremia, the extensive myocardial damage as with myocarditis in acute rheumatic fever." Heart failure may also produce abdominal, usually epigastric, pain regardless of the cause of the heart failure.[8]

Among the diseases of the heart which may produce abdominal pain is rheumatic fever, since it may lead to coronary thrombosis or congestive failure, and it may *per se* cause abdominal pain.[4,16,21,23] Usually the abdominal pain of rheumatic fever precedes the joint manifestations by two or more days.[21] It has been postulated that the pain is due to ischemia of the visceral organs resulting from the well-known changes which may occur in rheumatic fever, but further study has revealed that the pain is not related to the pathological changes in the vessels.[3] Since rheumatic fever tends to attack structures of mesodermal origin, it is probable that a true peritonitis exists, explaining the pain. The tenderness of the abdomen in such cases is out of proportion to the general appearance of the patient; therefore, one finds more tenderness than expected before examination. With the attacks one rarely finds vomiting as a symptom. One may be able to diagnose rheumatic fever by the changes in the white count and Schilling hemogram, the sedimentation rate, the electrocardiogram, the presence of changing cardiac murmurs, changes in rhythm, tachycardia, fever, the presence of chorea, and the response to salicylates.

Generalized diseases of the vascular system may likewise produce abdominal pain. Dunphy[19] reports seven out of twelve patients dying of mesenteric vascular occlusion gave a history of chronic recurring abdominal pain before the fatal attack. In these patients the pain did not radiate, was not sharply localized, and was not associated with muscle spasm or abdominal tenderness. Such pain characteristics were compatible with the pain of rheumatic fever.

Serum sickness, presumably by causing generalized capillary changes, has been reported as a cause of acute abdominal pain simulating a surgical emergency.[18] In such cases a history of previous serum therapy would be helpful in establishing the diagnosis. The usual sequence of events is one of a rather sudden onset of vomiting, pallor, small pulse, and abdominal pain—in general, a "shock-like" picture. These symptoms are followed in twelve to fourteen hours by a generalized urticarial dermatitis. There may occur at this time bloody diarrhea, and it has been shown that the intestinal wall is swollen and edematous throughout, with serum exudation. The edema produces a stiffening of the bowel, hindering peristalsis. In like manner, Henoch's purpura may be considered as an anaphylactic vascular reaction

of the gastrointestinal tract, producing abdominal pain with bloody diarrhea.

Intestinal allergies have become an increasingly recognized cause of abdominal pain, especially in children.[37] Along with the pain may appear urticaria or purpura. The diagnosis can usually be made by family history or allergy, a past history of allergy in the patient, a previous history of a specific food allergy,[22] and a leukocytosis with eosinophilia, if present. A test allergic meal may be given, and conversely the pain disappears upon elimination of the offending allergen.

Periarteritis nodosa, a much rarer condition, may produce abdominal pain simulating pancreatitis, cholecystitis, nephritis, appendicitis, and many other conditions of surgical import. The diagnosis may be suspected in an individual who gives a history of previous serum therapy, sulfonamide therapy in the presence of streptococcal infections, a dermatitis of hemorrhagic or urticarial nature, leukocytosis and eosinophilia, and a remittent type fever. The diagnosis is established by a biopsy of an affected vessel.

A much rarer condition of the cardiovascular system causing abdominal pain is that of spontaneous rupture of the heart.[38] This condition occurs most frequently five to eight days following a myocardial infarction and occurs in the infarcted area, usually of the left ventricle.

Of the diseases of the respiratory system, pneumonia and pulmonary infarction are notorious. Many cases of lobar pneumonia have been recorded as having had epigastric pain simulating early appendicitis as the presenting symptom. Diseases other than pneumonia and infarction may produce epigastric pain, including pulmonary abscesses, gangrene, empyema, and carcinoma. The problem arises in the early differentiation of lobar pneumonia from appendicitis. One method of differentiation has been suggested using physical examination of abdominal and thoracic excursions. The same results were obtained in patients with pneumococcal peritonitis, nephrolithiasis, fracture of ilium, and traumatic rupture of the kidney and suprarenals. Further, restriction of the abdominal respiratory movements was absent in cases of lobar pneumonia even though abdominal tenderness and rigidity were present. Usually after the first twenty-four hours one has no difficulty in recognizing these distinct disease entities.

Certain diseases of the nervous system are prone to cause acute abdominal pain, among them epilepsy, tabes, spinal cord lesions, intercostal neuralgia, herpes zoster, psychoses, and emotional strain.[2,4,7,15,16,20,21,23,26,28,29,32,37]

In the diagnosis of spinal cord lesions, of prime importance is the neurological examination. This should include muscle power tests, pain and temperature distribution, touch disturbances, sweating reflex, and the gnostic test. With a complete neurological examination, intra-abdominal causes of abdominal pain may be ruled out.

Tabes is well known for its ability to produce abdominal pain in the nature of the so-called tabetic crisis. Such pain is supposedly due to envolvement of the lateral tracts of the cord. The pain in these patients is of an intolerable nature, being rather constant and requiring unusually large amounts of morphine for relief. In the diagnosis one should rely on the findings of the spinal fluid serology and the pupillary reflex. A positive history of lues five to twenty years previously should be very suggestive.

Epilepsy may cause severe abdominal pain which is sudden in onset and with an increase in peristaltic movements.[36] There is no associated nausea or vomiting. A certain group of epileptics may have such complaints as abdominal pain as the sole manifestation of their disease. A positive diagnosis could be entertained through the electroencephalogram.

Intercostal neuralgia is a complaint heard frequently from the laity, yet at times it may be confused with intra-abdominal pathology. Certain physical tests have been devised to differentiate the pain of visceral pathologic conditions from the pain due to intercostal neuralgia. Carnett[15] states that parietal tenderness is always found to persist on vigorous palpation made while the patient balloons out the abdominal wall, making it impossible for the examining fingers to come in contact with the abdominal viscera. Ninety-five per cent of hyperalgesia can be demonstrated by pinching a liberal fold of adbominal fat and skin.[15] To divide the tests further one may find the point of tenderness and then ask the patient to tense the abdominal musculature raising the fingers away from the abdominal viscera. If the pain is thus made worse or remains the same one may assume the etiology of the pain is extra-abdominally located.[32]

In passing, herpes zoster is worthy of short mention due to the problem of diagnosis. After prod-

romal symptoms of fever, malaise, and pain along the course of the nerve lasting three to four days, a vesicular eruption appears. The eruption follows closely the course of the nerves for that dermatome affected.

Psychoses and emotional strain account for many cases of abdominal pain. Such pain is bizarre, unusual, and indefinite, the patient being unable to describe it with accuracy. These patients may even have nausea and vomiting associated with the pain. Usually the episode of pain lasts only a few minutes without residual tenderness. The following is an excerpt from one of Lambert's[29] patients, a small girl:

> "The father doll: 'I wish I had a boy instead of a girl.' 'Perhaps we can,' replied the mother doll. The child stepped out of character to remark, 'That's just like me: I have a step-daddy; I don't like to call him step-daddy, just daddy.' Then pointing to the father doll, the patient said, 'He beats the little girl because she spills some milk. She feels bad because he don't like her. She's scared and it makes her stomach hurt.' "

Many cases similar to the one above have been reported. The children becoming psychically frustrated have abdominal pain. Severe complications never develop from emotional causes of pain and there is no danger to life. "Such pain has no relation to the digestive cycle, or to defecation, menstruation, urination, or bodily exertion. The patient is completely well between spells. Such a person is likely to be nervous, worrisome, temperamental, and Jewish."[2]

Diseases of the blood which are generalized and do not affect the peritoneum directly may cause abdominal pain. Such diseases are those as Henoch's purpura, hemolytic icterus, and diseases in general leading to splenic enlargements. In a greater percentage of patients with hemolytic icterus there is a concomitant cholelithiasis which *per se* may cause the picture of an acute abdomen. This is not the explanation of abdominal pain, however, in all cases of hemolytic icterus. The abdominal pain occurs during the hemolytic crisis and may occur in diseases or conditions other than hemolytic icterus producing rapid hemolysis of erythrocytes. One laboratory examination which may rule hemolysis out or in as a cause of abdominal pain is that of the determination of free hemoglobin in the serum, which is elevated during hemolytic crises. There may be subsequent thromboses following such crises causing further pathology, but generally the pain is one of acute tissue anoxia.[14] Hemolytic icterus is usually diagnosed by the positive family history, splenomegaly, increased icterus index, increase in platelets, reticulocytes and white blood cells after a hemolytic crisis, and the abnormal fragility of the red cells to saline.

Sickle-cell anemia is a frequent cause of abdominal pain seen in the Negro race when no other cause is obvious. The pain may be generalized, unilateral, upper or lower abdominal in location. Vomiting may occur in such crises. Remissions and exacerbations is the natural history of the disease. The x-ray is helpful in establishing a diagnosis and reveals a furring, as of hair standing on end, of the outer cranial table. Smears made and subjected to carbon dioxide show the sickling. It has been stated that 7 to 10 per cent of all Negroes have an inherent tendency for sickling.[30]

Of the metabolic disorders, diabetic acidosis is probably a common cause in the production of abdominal pain. One can easily visualize the results of operating on a patient suspected of having appendicitis when in reality he has diabetic acidosis. Surgery in the diabetic presents itself as a problem notwithstanding surgery in the patient with diabetic acidosis. In diabetic coma one usually finds the vomiting has preceded the pain, whereas the reverse is true with an intra-abdominal pathologic condition.[41] With appropriate therapy in diabetic acidosis the abdominal pain of nonsurgical import clears, while that due to organic lesions progresses. In such patients the onset may be sudden with nausea, and vomiting followed by abdominal pain. Usually one finds a leukocytosis and a fever exceeding 99° F. The abdominal pain is supposedly caused by a hypochloremia, since a correction in the blood sugar and carbon dioxide combining power without a correction in the chlorides is not accompanied by a relief of the abdominal pain. Once diabetic acidosis is suspected, it is relatively simple to confirm such a suspicion with a urinalysis for sugar and acetone bodies, a high blood sugar, and a low carbon dioxide combining power. On acute emergencies with a known pathologic condition occurring concomitantly with diabetic acidosis, it has been said that operation should not be undertaken with a carbon dioxide combining power of less than 40 volumes per cent.

Of the direct opposite from diabetes is the condition of hypoglycemia which is able to produce

abdominal pain. In such conditions one must rely greatly upon the history of previous attacks and the association with meals. It is rather frequent to hear the story of abdominal pain or even precordial pain coming on at midnight after the patient has retired. Again one may obtain a history of such attacks of weakness, palpitation, tremors, sweating, and hunger after periods of physical exertion.[11] The diagnosis is obtained from the determination of a glucose tolerance test. Surgical procedures in such a patient with abdominal pain may be timely interrupted by the determination of a blood sugar at the instance when the patient has the pain.

Certain patients suffering from occult or marked hypothyroidism may have abdominal pain. The onset of the pain is usually related to meals in that it occurs several hours after meals. Such patients may show nervousness, irritability, insomnia, mental depression and instability, dry skin, falling hair, and pain in the epigastrium.[25] They may be mistakenly diagnosed as having peptic ulcer. The pain is not due to colonic states or constipation,[9] but may be explained on the poor absorptive ability of the gut due to the mucinous edema of this structure. The diagnosis may be obtained by finding a high blood cholesterol, a leukopenia, a low blood pressure, a low basal metabolic rate, and the therapeutic response to thyroxin.

Formerly, a frequent cause of abdominal pain in children was plumbism. The children would eat the lead point of the bed, ingesting sufficient amounts to produce symptoms of toxicity. Such symptoms are irritability, restlessness, fretfulness, nerve palsies, convulsions, nausea, vomiting, epigastric pain, and constipation. Abdominal pain and vomiting is found fairly frequently in children.[40] Such a condition may be diagnosed by a history of exposure, the symptoms of intoxication, basophilic stippling of the erythrocytes, and increased density of the bone shadows on x-ray examination.

Intracranial neoplasms may produce abdominal pain, most commonly those of the frontal lobe. The diagnosis of such a lesion is confirmed by a complete neurological examination, the history of psychic changes and/or epileptiform convulsions in the patients, studies on the cerebrospinal fluid, and ventriculographic studies.

A cause of abdominal pain being recognized more in recent years are the silent cerebral strokes of Alvarez. These occur most commonly in middle aged individuals and may be represented symptomatically by nausea, vomiting, and pain in the abdomen. Commonly such individuals are left with residual nervous system damage manifest by a hemiparesis, facial paresis, or paresis of one or more muscle groups.

In addition to the above causes of abdominal pain, others occur which bear mentioning. Carcinoma of the testes and prostate may produce a symptomatic acute abdomen.[27] Pressure over the prostate may produce the typical pain. This is particularly true in suppurative prostatitis.[39] A prostatic smear will reveal many pus cells in the latter instance.

In addition to those known causes there remain those causes for which no organic basis can be found.[24]

In view of the foregoing, it would appear wise for the surgeon to yield a diagnosis before he wields a knife in those patients presenting themselves with acute abdominal pain as the chief complaint.

References

1. Alvarez, Walter C.: Abdominal discomforts for which no organic cause can be found. M. Clin. North America, 23:887, 1939.
2. Alvarez, Walter C., and Hinshaw, H. Corwin: Severe abdominal pains that follow an emotional storm. M. Clin. North America, 19:399, 1935.
3. Apfel, Harry: Pain in the abdomen: an early symptom of rheumatic fever. Arch. Ped., 61:409, 1944.
4. Appelbaum, H. S.: Differential diagnosis of right upper abdominal pain. Ohio State M. J., 35:278, 1939.
5. Aynesworth, Kenneth H.: Epigastric symptoms in acute lung and heart disease. Ann. Surg., 105:845, 1937.
6. Baker, Paul S.; Wilson, Frank N., and Coller, Frederick A.: Abdominal disease simulating coronary occlusion. Am. J. M. Sc., 188:219, 1934.
7. Baland, Frank K.: The interpretation of abdominal pain. South. M. J., 28:133, 1935.
8. Ballinger, William M.: Lower chest and upper abdominal pain. Ann. Int. Med., 12:1223, 1939.
9. Bassler, Anthony: Three cases of marked hypothyroidism having abdominal symptoms. Endocrinol., 26:218, 1940.
10. Bothe, Frederick A., and Beardwood, Joseph T.: The evaluation of abdominal pain in the diabetic. Ann. Surg., 105: 516, 1937.
11. Brown, Merle J.: Hypoglycemia and abdominal pain. Am. J. Surg., 64:276, 1944.
12. Brown, Thomas R.: Abdominal pain: its significance and diagnostic value. Ann. Int. Med., 8:343, 1934-35.
13. Camp, Stanley: Cardiologic significance of epigastric pain. South. M. J., 30:839, 1937.
14. Canby, Charles B.; Carpenter, Gurth, and Ellmore, Lewis T.: Drepanocytosis and an apparently acute surgical condition of the abdomen. Arch. Surg., 48:123, 1944.
15. Carnett, John B., and Bates, William: The diagnosis of intercostal neuralgia of the abdominal wall. Ann. Surg., 98:820, 1933.
16. Comroe, Bernard I.: Nonsurgical causes of acute abdominal pain. Ann. Surg., 101:438, 1935.
17. Cope, Zachary: The Early Diagnosis of the Acute Abdomen. Ed. 9. New York. Oxford University Press, 1946.
18. Derbes, Vincent J., and Bruno, Frances E.: Serum sickness simulating acute abdominal disorders. Surgery, 13:450, 1943.
19. Dunphy, J. E.: Abdominal pain of vascular origin. Am. J. M. Sc., 192:109, 1936.
20. Eliason, E. L., and Erb, William: Surgical significance of abdominal pain. S. Clin. North America, 15:21, 1935.

(Continued on Page 125)

Acute Surgical Conditions of the Abdomen

By Arnold S. Jackson, M.D.
Madison, Wisconsin

IN THE BELIEF that much of medical literature is repetition and that there is so much presented that lack of time demands that the subject be given in as few words as possible, a year ago I began a movement for the purpose of streamlining medical papers.

The subject of acute surgical conditions of the abdomen is one of such magnitude that books have been written on merely certain phases of it. Therefore, if I am to practice what I preach, this paper will only touch upon a few of the most important diagnostic and surgical problems.

Just recently the following unusual cases were presented at our clinic within the lapse of a few days.

A nine-year-old boy who had been kicked in the abdomen by a cow thirty-six hours before his admission was brought in from a distance of eighty miles. His physician had seen the boy shortly after he was hurt, but because the abdomen was soft and bore no external mark and because the youngster appeared to be in good condition, he failed to realize the seriousness of the condition. Actually, the boy had sustained a rupture of the jejunum, the bowel being nearly severed, and soon after admission to the hospital he died of shock and peritonitis. Yet I could not criticize this physician for his failure because I had made a similar mistake my first year in practice. In that instance a boy had been kicked in the abdomen during a football game. He, too, appeared to be in good condition on admission. His abdomen was soft, and there was no external mark. It happened at night, and I was already confronted with a patient with a strangulated hernia and one with perforated ulcer. The football player seemed the least seriously ill of the three. It was an unfortunate decision. The other patients might better have waited an hour or two because this boy died the following day of a ruptured jejunum. Yet that same morning he sat on the side of his bed smoking a cigarette and joking with his ward companions. His sense of well-being completely deceived one, as did the slight abdominal rigidity, which I wrongly attributed to voluntary muscle spasm and external trauma.

That was twenty-seven years ago, and this costly error in judgment, which I am afraid has happened to many others, taught me a lesson that has since saved numerous lives. How are we to correctly diagnose such cases in the presence of a soft abdomen, normal temperature and blood count, and the absence of shock or any visible external marking within a few hours of the onset? Experience and judgment alone must be our guide. If your patient is in a farmhouse or a small town lacking proper hospital facilities and experienced consultants, transport him as speedily and gently as possible to a good hospital. Do not give him morphine and mask the picture unless you think he has an acute surgical condition of the abdomen and must be operated upon at once.

I believe that the community in which I live is as enlightened medically as most any section of the country, yet my medical experience has been studded with unfortunate disasters because, in an effort to relieve pain, some well-meaning physician has administered morphine, confusing the diagnosis until the critical nature of the condition became apparent. I have seen the patient with a perforated ulcer who is relieved of pain only to die of peritonitis, the patient with a ruptured spleen or liver who is relieved of apprehension temporarily and later dies in shock and hemorrhage, and the child with a retrocecal appendix deep in the abdomen, who, because of the soft belly, normal temperature, and normal blood count, is given a sedative and a laxative, and dies a few days later of peritonitis.

To return to the boy whose death resulted from a cow's kick which ruptured the jejunum, I believe there is only one rule we can follow in such traumatic lesions, namely, when in doubt, *operate*. A negative exploration will do little or no harm, and it may prove life saving. With the aid of antibiotics and good surgery, few such patients should die if operated upon within the first few hours, but every hour's delay adds to the risk.

The same night this boy was admitted I was called to see a fifty-year-old man who was sitting upright in bed complaining of severe abdominal pain. He had every appearance of an acute perforated ulcer. He was unable to lie down; he was perspiring and suffering; and even the x-ray plate showed a suspicious area suggesting a gas

From the Jackson Clinic, Madison, Wisconsin.
Presented at the eighty-fourth annual session of the Michigan State Medical Society at Grand Rapids, September 23, 1949.

bubble under the left diaphragm. Yet he did not have a perforated ulcer, and I was fairly sure of my diagnosis. Do you know why? In eliciting his history—and it is most important that a careful history be taken in these cases—the fact was brought out that the onset of the pain was gradual and not *gunshot* in character. If I recall correctly, every patient with perforated ulcer whom I have seen had this history of a sudden severe pain. Often it comes when the stomach is empty and after drinking cold beer. Only about 70 per cent of the patients give a previous ulcer history. Boardlike rigidity developing an hour or two after onset is typical. When this man's attention was directed from his trouble, his abdomen relaxed; in patients with perforated ulcer this does not happen. The temperature and blood count rise only as peritonitis begins to develop. Do not delay in getting these patients to the operating table, for minutes are valuable and hours may mean life or death. A few interrupted chromic sutures will close the perforation; a tag of omentum over the sutures will help; penicillin, sulfonamides, and streptomycin will combat infection. As with all my surgical cases I have the patient out of bed the day of operation and, if possible, walking the day after. Long an early ambulation enthusiast, I believe this is the best way to combat such conditions as ileus, atelectasis, pneumonia, embolism, and wound disruption. Venoclysis and careful attention to maintenance of the proper electrolytic balance, as so often advocated by your own eminent Fred Collyer, are all important. I have had no experience with the nonsurgical treatment of these cases now being tried at Johns Hopkins and elsewhere. Unless the patient is in the late stages of peritonitis, I prefer closure of the perforation and nondrainage. As it turned out, this patient did not have a perforated ulcer but was suffering from acute gastritis.

A few days later I was asked to hurry to the emergency department for consultation. The patient, a middle-aged man, said that ten days before, while walking through his barn, he struck his side against the sharp edge of a box. He was driven thirty miles to the clinic, his chest was x-rayed and strapped, and he was then allowed to go home. After a week he removed the tape and on this day brought his daughter to the clinic. While sitting in the car awaiting her, he sneezed and felt a sharp pain on his left side. He walked into the clinic, sat down, and was soon observed by a nurse, who noted that he looked pale and took him to the emergency department. On seeing the man, I found that his pulse was 50 and his blood pressure normal. His abdomen showed slight voluntary rigidity but no area of tenderness. At this time he laughed and talked with me and seemed in no obvious distress. He was taken to the x-ray department to have a flat plate of the abdomen, and from there I was called and told that he "nearly passed out on the way." However, when I arrived, his condition appeared excellent, and the x-ray plate was negative. Two hours later I removed a ruptured spleen. This was an unusual case of delayed hemorrhage following external trauma. Nature temporarily took care of the torn spleen, which was opened up by his sneezing and every time he was put in a certain position. A falling blood pressure and a rising weakened pulse called for immediate exploration, and our assumption that he had sustained a ruptured spleen or liver proved correct.

I could go on indefinitely citing interesting cases such as these to illustrate the various problems found in acute surgical conditions of the abdomen. All of you, I am sure, have had many similar problems to solve, but we must hasten on to mention briefly some of the other twenty or more lesions that test our diagnostic acumen.

First, let us not overlook the purely medical diseases that may mimic surgical lesions.

The onset of pneumonia in children may occasionally cause abdominal complaints that simulate appendicitis. In acute pyelitis there may be elevation of the temperature and the white blood count and, at first, negative urinary findings. True, the tenderness is usually in the lumbar region. In appendicitis, too, there may be little tenderness and rigidity, a normal blood count, and even blood cells and pus in the urine to still further confuse the differential diagnosis. Coronary disease may resemble acute cholecystitis and vice versa; not infrequently they may occur together. Abdominal allergic conditions and abdominal apoplexy may be puzzling.

Acute pancreatitis is considered by some as a surgical condition and by others as a medical disease. Recently one of my colleagues and I operated upon two patients with acute gangrenous hemorrhagic pancreatitis, and both recovered. I cannot see how these critically ill patients would have survived without surgical intervention. Yet, Doctors Ochsner and Gage told me recently that

they had successfully treated over forty cases of acute pancreatitis by lumbar sympathectomy block. The diagnosis of these cases is often not as simple as the textbook description of high fever, severe epigastric pain, leukocytosis, shock, and positive blood amylase findings. Most of the patients I have operated upon seemed to have conditions so closely resembling cholecystitis that exploration was deemed advisable, and with the aid of antibiotics I believe the mortality has been greatly reduced.

In acute cholecystitis one expects to find the signs confined to the right upper quadrant with the pain often referred to the right costal margin and infrascapular area. The diagnosis is usually not difficult, although at times the possibility of a high-lying appendix may be confusing. The main point of discussion in this condition is when to operate. One school of thought favors early cholecystectomy and the other delayed surgery. I believe there can be no fixed rule, and the same applies to removal or just drainage of the gall bladder. It is better to have a live patient than a perfect operation and a fatality. Consequently, in the elderly, the debilitated, or in the presence of severe toxemia, cholecystostomy may be preferable to cholecystectomy.

Acute intestinal obstruction still remains the cause of high mortality, despite advancement in anesthesia, technique, and chemotherapy. Too often diagnosis is delayed too long because of a normal temperature and blood count and absence of fecal vomiting and of severe distress. In the past the mortality has been as high as 50 per cent in the best hospitals, but improved methods of preoperative and postoperative care, earlier recognition and operation, and the use of oxygen and penicillin have greatly lowered mortality. Intussusception, volvulus, adhesions, strangulated hernia, and malignant growths all take their toll. High obstruction with the history of cramping pains, vomiting becoming fecal in the late stages, visible peristalsis, distended abdomen, obstipation, and the characteristic stepladder appearance of the flat x-ray plate are all typical. Always examine the abdomen for an operative scar that may disclose the cause of adhesive bands. If in doubt, do not delay an exploration. Obstruction in the large bowel is more gradual in onset, especially if due to malignancy, and is not as quickly detected. The Miller-Abbott tube, hot stupes, enemas, and venoclysis may temporarily relieve a partial obstruction of the large bowel and improve the patient's condition for operation. The patient usually recovers from an operation unless it has been too long delayed. In acute intestinal obstruction I prefer to be as conservative as possible and seldom resect the bowel. Early ambulation and duodenal suction, with careful attention to the electrolytic balance, and oxygen are helpful.

Mesenteric thrombosis may present the typical picture of auricular fibrillation, bloody rectal discharge, abdominal distress, and doughy abdomen. Often as not the characteristic textbook picture is not seen, but there is no mistaking the diagnosis when the peritoneum is opened, and the only recourse is to resect the gangrenous intestine, start heparin and dicumarol, and pray. Usually it does no good, but rarely a patient may survive.

Among the numerous conditions for which appendectomy has been performed in the absence of appendicitis is a lesion involving almost any segment of the small or large intestine and first described by Krohn and his associates in 1932. This condition they termed terminal ileitis, but now it is generally called regional enteritis. It is a baffling disease of unknown etiology, whose cure likewise remains a mystery. Probably no subject in surgery was given more space in the national and state medical journals during the ten years following this report. In 1936 I brought the cases in the literature up to date and collected sixty-four additional cases from members of the Western Surgical Association, including four of my own, making a total of 182 cases. This report appeared in *Surgery, Gynecology, and Obstetrics* and was illustrated by a colored plate showing the typical, edematous, thickened appearance of the diseased bowel and the greatly enlarged glands. Since that report, many hundreds of additional cases have been added to the literature. Some authors have favored resection, others prefer sidetracking the diseased area, and still others have opposed surgery in any form. In brief, this condition may in its early stages simulate acute appendicitis, later on acute ulcerative colitis, then intestinal obstruction, and in the last stage multiple fistula between loops of intestine or the bladder may occur.

Congenital anomalies of the abdomen form an entire chapter in themselves, and in my experience there have been cases of hemorrhage, perforation, and strangulation from but one of these, Meckel's diverticulum. My associate, Dr. George Schwei, and I have recently completed a study of thirty-

eight such cases.* Time does not suffice to permit a further discussion of this subject, other than to say that this lesion is not an unusual cause of acute intestinal hemorrhage.

There are numerous other abdominal conditions that call for immediate surgery, and among those conditions in which I have operated have been three cases of torsion of the omentum, and one of almost fatal hemorrhage from a leiomyoma of the ileum. One must always bear in mind, too, the large group of pelvic lesions, ruptured ectopic pregnancy, and torsion of or rupture of an ovarian cyst. Then, too, the various inflammatory lesions must be ruled out, but these conditions are not within the scope of this paper.

There remains time to mention but briefly the most important of all acute lesions of the abdomen. In 1938 I wrote a paper entitled "Half a Million Deaths from Appendictis," the object of which was to stress the appalling and increasing death rate from this disease. Many more of our finest young men and women have died since publication of this paper, but with the advent of the sulfonamides in 1941 and with the later introduction of penicillin and streptomycin the death rate has rapidly decreased from three every hour, or 17,000 a year, to probably less than 5,000 this year. That figure is still far too high. Unfortunately this disease may prove to be the most baffling, from a diagnostic standpoint, of acute abdominal conditions; and to reiterate, despite a normal temperature and blood count and a soft abdomen with tenderness only on deep palpation, operate if you think it is a case of appendicitis. Since 1941 in perforated appendicitis with peritonitis I have used sulfathiazole intraperitoneally, and, more recently, penicillin and streptomycin, no drainage, and early ambulation, with recovery in all cases and without wound infection. These measures have been a great forward step, not only in eliminating mortality and complications, but also in reducing hospital stay and convalescence.

This, in brief, is a streamlined presentation of the more important acute surgical conditions of the abdomen, adequate treatment of which would require one or more volumes.

MSMS

It costs the Government from $22,000 to $55,000 per bed to build hospitals. The Civilian cost is about $16,000 for the same kind of bed.—*Hoover Commission Report.*

*In press, *American Journal of Surgery.*

Recto-urethral Fistula

By J. F. Wenzel, M.D., and E. A. Jenkins, M.D.
Detroit, Michigan

THE REPAIR of simple anocutaneous fistula by the excision of tract and overlying tissue, without suture, allows healing by second intention, without recurrence.

Recto-urethral fistula, with both urine and feces forced into the tract, has a high recurrence rate following surgical excision. The overlying tissue cannot be removed to permit healing by granulation. Recurrence is due to contamination of the operative site by urine or feces after the tract has been removed. Healing by second intention can be obtained by keeping the operative site free from either urine or feces. The wound cannot be considered sterile, and reliance cannot be placed on healing by first intention.

In 1913 in the Transactions of the American Association of Genito-Urinary Surgeons, Young and Stone described a modified pull-through procedure, utilizing only the rectal mucosa, to divert the fecal stream beyond the area of repair, thus avoiding temporary colostomy. Antecedent suprapubic drainage of the bladder diverted the urinary stream from the operative site. The diversion of the fecal stream and diversion of the urinary stream remain basically fundamental in the surgical repair of recto-urethral fistula.

Case Report

On January 5, 1948, C. R., an eight-year-old boy was admitted to St. Mary's Hospital in Detroit with a history of having been born with an absent anus, which was corrected immediately by suture of the blind rectal pouch to the perineum. Since that time urine passed through the rectum, and feces and gass passed through the urethra. The anus was always painful and a diaper always necessary. Constipation was severe.

Intravenous pyelography revealed compression of the bladder by bowel dilated with feces sufficient to be consistent with a diagnosis of megacolon; there was no evidence of fistula connecting the bladder and bowel (Fig. 1). Methylene blue injected through a catheter into the bladder did not appear in the rectum. Peroxide injected through the urethral meatus appeared in the rectum 2 cm. above the anocutaneous junction. A catheter was then passed into the urethra through the fistula into the rectum and out the anus (Fig. 2). The urinary opening was thus established at or distal to the external urinary sphincter.

Presented before the Philadelphia Proctologic Society, March 16, 1949.

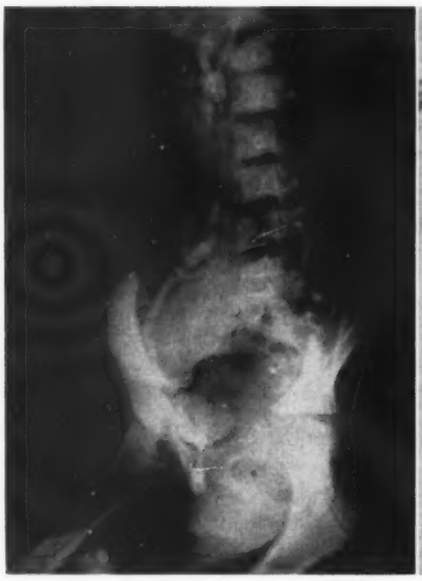


Fig. 1. Intravenous pyelogram revealing bladder compression and hydro-ureter resulting from impacted feces; no fistula exists between bladder and bowel.

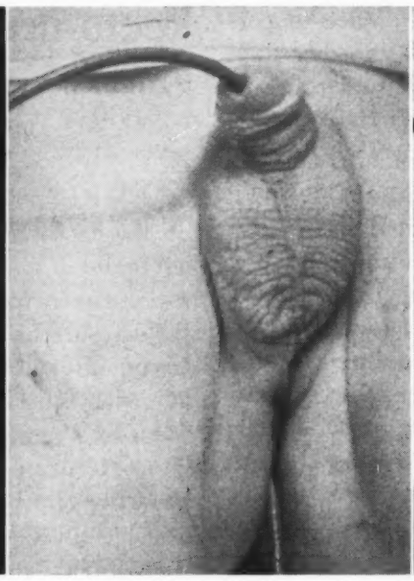


Fig. 2. Recto-urethral fistula. Catheter passed into urethra, through fistula into rectum, and out of anus.

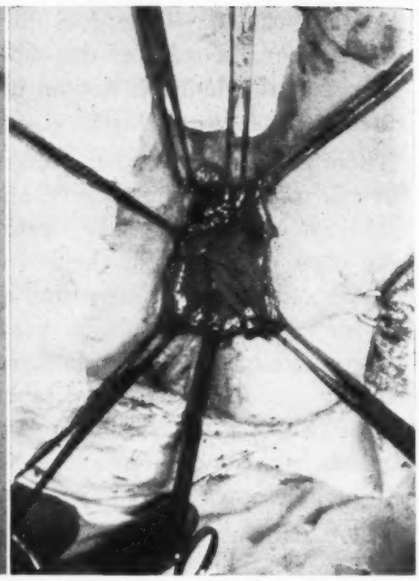


Fig. 3. Mobilized rectum pulled through anus, transplanting fistulous opening beyond skin line.

After bowel preparation the patient was taken to the operating room on January 20, 1948. No colostomy was used. Suprapubic cystostomy was performed to divert the urinary stream; urethral drainage with a Foley catheter was established to supplement urinary diversion and to aid in the urethral dissection. A collar incision was made at the anorectal junction, and the rectal wall, including all layers, was mobilized by sharp dissection up to the peritoneal reflection. The mobilized rectum was retracted and the fistulous tract excised. The urethral lining was freshened and the wound closed with No. 00 chromic catgut. The mobilized rectum was pulled through the anus, transplanting the fistulous opening to the outside, and the redundancy excised (Fig. 3).

Urinary drainage was continued for two weeks. Cystoscopy every two months for over one year revealed no stricture and no recurrence of fistula. The urinary stream was forceful and there was no incontinence. Anoplasty for anal stricture was done six months later, resulting in adequate bowel regulation and control.

Conclusion

By diversion of both fecal and urinary streams, surgical repair of recto-urethral fistula can be converted to the principles of healing by second intention, as in simple anocutaneous fistula.

MSMS

EFFICIENT?

The Metropolitan Life Insurance Company and the Federal Government both are in the insurance business. It takes four times as many employes in the Federal Government to process a given number of claims as it does the Metropolitan Life Insurance Company.—*Hoover Commission Report.*

CANCER CONTROL

(Continued from Page 20)

cancer incidence and prevalence are still most inadequate, cancer reporting is being rapidly extended to all states. Official public health agencies are appreciating that cancer is a public health problem and are making its control a part of their regular duties.

An increasing number of cancer patients now receive treatment in earlier stages of their disease. This increases the number and percentage of five-year cures which, in turn, creates a greater optimism in both lay and professional minds.

Cancer research has been extended into all phases of the cancer problem. More than 200 research projects are now focussed on the problem of growth. Studies in physics, chemistry and related sciences are being pursued. Clinical studies on diagnosis, treatment and care of cancer patients are being conducted. Tissue culture methods now provide adequate quantities of cancer tissue for study and large numbers of genetically homogeneous laboratory animals, principally mice, are providing material for important cancer studies. A never-ending search for the cause, cure and control of cancer will continue to shed light on this problem that has baffled the scientific world from the dawn of history. There is much cause for optimism in ultimately understanding and controlling this disease.

Mental Illness

Administrative, Preventive and Therapeutic Considerations

By Alfred E. Eyres, M.D.
Detroit, Michigan

MENTAL ILLNESS is grim and serious. There are eight million[20] of us who are seriously psychoneurotic and three million who are chronically alcoholic. One in fifty will commit suicide and one in fifteen will be committed to a mental hospital. Ten years ago Halliday[12,13] first called attention to the rising incidence of emotional illness. The tremendous numbers of rejections by selective service boards in World War II and the great numbers of neuropsychiatric casualties should certainly give cause for concern and reason for action. The majority of patients seen by physicians have no demonstrative tissue pathology but are ill because of emotional stress and strain.

The student of medicine today is confronted with a panorama quite different from that of his predecessors. The health officer, a specialist in preventive medicine, is aware of the fact that such illnesses as typhoid, pneumonia, smallpox, diphtheria and scarlet fever are largely controlled or eliminated. Preventive medicine will continue its inroads in the direction of the infectious diseases. As we become a nation of older people, we must pause and consider that which Boas[3] has called the Unseen Plague, Chronic Disease. What is the unseen plague and of what does it consist? There are nervous and mental illness, rheumatic disease, accidents, allergy, and cardiovascular-renal disease, of which essential hypertension alone outweighs cancer in importance.[16,28] According to the statistics of the Metropolitan Life Insurance Company,[5] every other individual past the age of fifty years dies of cardiovascular-renal disease. The most singularly important fact here is that emotional factors very often play an important part.[21,24] Fleming[10] and Halliday[14,15] have called attention to the magnitude of the accident and illness habit and its association with the emotional component. The figures and estimates of the National Safety Council[25] are stifling and almost beyond understanding. The 1941 accident rate, averaging one death or disabling injury for every four families, took a larger toll than the army. In 1941 four million workers were killed or seriously injured, and nearly one half billion man-days, sufficient production labor to have probably doubled the United States Fleet, were lost. Against the gargantuan problems of crime, costing fifteen billions of dollars yearly, juvenile delinquency, divorce, relief and the dole, the potentialities of preventive mental medicine may have some of the answers.

Another important consideration that Dunbar[6] has pointed out is that many patients discharged by qualified physicians from our best hospitals, as having no sign of demonstrable organic disease, remain sick and later drift to the quack, the charlatan, or return later with a recognizable organic disease which earlier symptoms suggested. The challenge is overwhelming and the stakes are enormous. We must cope with the problem of mental illness. Plans for so doing demand that all available resources be carefully integrated and placed at work if results are to be achieved.

Community Organization for Administration

Many of our people, physicians included, are not sufficiently cognizant that mental illness is, in terms of prognosis, not unlike other diseases, say—pulmonary tuberculosis, appendicitis or syphilis. By this, it is meant that in mental illness, as in other illness, the patient is much more apt to get well when very early treatment is instigated.

There are many who believe that the most ideal way to see emotional illness early is to see it in the general hospital. Heldt,[17,18] Sandy,[27] Menninger,[22] Billings[2] and a host of others have written extensively in this regard. The psychiatric general hospital movement undoubtedly will develop extensively, and from a social and an economic standpoint it must. As a result, the early study, diagnosis and treatment of the patient with emotional or psychosomatic illness will constitute a powerful prophylactic against the development of more severe disorder, and many patients will be spared state hospital commitments.

Many of the psychoses may be treated and recovery gained in the general hospital. The alcoholic psychoses, especially delirium tremens, constituting about 10 per cent of admissions to state hospitals, and the syphilitic psychoses, constituting another 5 to 10 per cent, are examples. The depressions, the involutional psychoses, the acute anxiety states and certain other entities may be treated in the general hospital. Psychotherapy,

physiotherapy, fever therapy, hydrotherapy, chemotherapy, insulin and electro-shock therapy, psychosurgery, recreational and occupational therapy constitute powerful and effective therapy measures in the treatment of these diseases, and they may readily be given in the general hospital.

There is urgent need for community mental hygiene clinics and child guidance clinics. Here is preventive medicine and preventive psychiatry in its most fruitful and efficient form. Indeed, our tardiness in placing at work the forces of preventive mental medicine is a tragic chapter in medical history.

The State Hospital

The state hospital of today is largely concerned with providing custodial care for patients. The state hospital of tomorrow should instigate an aggressive therapeutic program for the benefit of all patients. There are several prerequisites necessary if such a program is to be pursued. The legislature must appropriate ample funds; modern physical facilities must be forthcoming, trained personnel employed, and in certain hospitals facilities for the training of personnel must be organized.

Selection and Training of Personnel

The selection and training of personnel for psychiatric work is of paramount importance. Having a place in carefully organized and integrated training are administrators, physicians, nurses, dentists, psychologists, social workers, clergymen, occupational therapists, attendants and certain other employes in housekeeping and industry.

Any person electing to go into psychiatric work should have an interest in people and in emotional illness. More especially, nurses and attendants should be more carefully selected in the future. This is necessary because the patient spends the major portion of his time in the company of the nurse and the attendant. Careful investigation of the applicant, aptitude tests and interview by a psychiatrist are indicated.

Special courses of study should be given the attendant and other hospital employes who have contact with the patients.[4] The nurse should have, as an integrated part of her training, a six months' affiliation in an approved mental hospital either public or private.

In 1945 Menninger[23] estimated that only about 200 young physicians were receiving formal psychiatric training. As the military situation has permitted, increasing numbers of physicians have sought training. In addition to previously approved facilities for training, the reorganized Veterans' Administration is now providing training for physicians and the veteran is receiving sorely needed therapy. The classical treatise of Aring and Bateman,[1] "Nurturing a National Neurosis," which appeared in a 1937 issue of *The Journal of the American Medical Association* affirms the veteran's need for psychiatric therapy.

There is not yet complete agreement over what constitutes adequate training for the psychiatrist. It is nevertheless evident that present state hospital training is quite inadequate and needs to be supplemented. There exists, at present, a definite paucity of physicians in state hospitals. This may well be due to the fact that the state hospital must now compete with University Hospitals and general hospitals in the securing of trainees. Psychiatric training at its zenith certainly must make provision for clinical work other than with psychoses alone. Without an understanding of neuroses, child guidance work and psychosomatics there exists a vacuum in any training program. It becomes increasingly evident that psychoanalytic training is of sufficient importance that provision, at least from standpoint of time, must be made for those desiring such training. It is the opinion of English and Pearson[7] and a host of others that the more severe neuroses can be cured permanently only by psychoanalytic treatment.

Problems of Personnel and Morale in Employes and Trainees

Institutions and training centers, without exception, must deal with the ever present personnel and morale problem. The student of political science well knows that in the Supreme Court of the United States the personal element is not eliminated.

Capacity for action and degree of efficiency are perhaps more dependent on esprit de corps than any other single factor. The allocation of authority to departmental and divisional chiefs by the administrator is all important in good administration. By the same token, if there is definite cleavage between policy and administration, as there should be, the divisional and departmental heads are responsible and accountable to the administrator for their work.

The best of administration can be scuttled by vacillation, indifference, internal dissension, insubordination and disloyalty. Much has been written regarding morale and ways and means of maintaining it. Employes and trainees should have knowledge of purposes and objectives and they should be made constantly aware of the worthwhileness of their work. The confidence of the rank and file in the integrity and good intent of superiors is necessary. General personnel problems carefully and fairly handled will do much to enhance morale. Meriting mention are: equal compensation for equal rank; promotions on basis of merit and efficiency; equal opportunity of assignment to and rotation on various services, especially in reference to physicians and nurses; liberal policy on time-off, vacations, leaves, transfers, and, for the permanent employe, a satisfactory retirement system.

Good and effective leadership can build morale by effort in other directions. Cheerful and comfortable living quarters and the provision of good food pay immeasurable dividends. The trained nutritionist is the first prerequisite for balanced diet and palatable food. There are all together too many hospitals operating without the services of a nutritionist, and, moreover, diet is equally important for employe, trainee and patient. In the instance of trainees, the majority of whom are yet in formative years, it is an inexcusable indictment against a hospital and a municipality or a state if adequate diet is not provided. Prepared under the direction of a nutritionist, seasoned and cooked by a skilled and painstaking chef, could there be anything more delicious and nutritious than a beef stew? A diet that is palatable and balanced is indeed one of the paramount aspects of sound medical and administrative practice.

The employes and trainees should have access to modern recreational facilities. It is possible for employes to use most of the same facilities that should be provided for patients. A gymnasium for year-round use makes possible diversified activities such as softball, basketball, volleyball, handball, badminton, bowling, dancing and swimming.

Many general and psychiatric hospitals make provision for care and treatment of physical illness in employes. However, seldom is anything done for the employe in need of psychiatric guidance. Because emotional illness is of much higher incidence than physical illness, cognizance should be taken in regard to this problem. The psychosomatic illness and the psychoneuroses often respond quickly and readily to treatment. One of the first symptoms in emotional illness may be an impairment of working efficiency. Intelligent medical and hospital practice would be consummated if the employe were given reassurance and assistance in the solution of his conflicts.

The physician, in most institutions, is usually called upon for twenty-four-hour duty several times per week. This practice should be discontinued. In its place there should ensue a planned duty schedule, whereby for a given period of perhaps ten days, or two weeks, one physician would assume complete night house coverage and be free from daytime duty. The physician who pursues intensive academic and clinical daytime work, can be at his highest degree of efficiency only when his rest is regular, and it almost never is when twenty-four-hour coverage is imposed upon him.

The success or failure of treatment in any hospital is dependent upon the physician's leadership. If the state hospital hopes to carry on successful treatment and to train personnel effectively, which at its best is slow and tedious, it must attract and hold physicians of high caliber, by upward revision of salaries. Pay scales of other employes likewise should be increased. Security and tenure of position spell immunity against the ruthless politician and contribute to sound morale. Without a high degree of autonomy neither a department nor mental health nor a state hospital can do its best work. In security and tenure of position, Massachusetts has made progress. The law requires that the commissioner and the assistant commissioner of mental health and the superintendents of the State Hospitals be diplomates of the American Board of Psychiatry and Neurology.

Physical Facilities

The efficiency factor of any hospital is in considerable measure dependent upon the quality and arrangement of buildings and grounds, and upon other essential equipment and capital outlay.

Because of extensive research in architectural engineering, materials and working plans, the new psychiatric hospital can be constructed with operating efficiency as its highest goal. The remodeling of older units entailing definite limitations is nevertheless often desirable and feasible.

Bricks and mortar are important, but there is

yet much to be attained. What are some of the more important and necessary physical facilities for a modern psychiatric hospital? For the treatment and care of patients: modern equipment for surgical, obstetrical and medical care, including geriatric care; clinical laboratories; x-ray, including the miniature type; apparatus for physiotherapy, fevertherapy, hydrotherapy, and shock therapy; miscellaneous equipment for research work; dental office and laboratory; extensive recreational and occupational therapy and outlay; modern equipment concerned with functions of housekeeping.

There are few, if any, mental hospitals that can afford to operate without continuous intermittent sanitary surveys, conducted by a qualified sanitary engineer. Sanitary science is highly technical, has extensive ramifications, and too little attention is paid to it. Mental hospitals are powder kegs of dysentery, typhoid and other foodborne infections.

Treatment and Care of Patients

The fulcrum of therapy is occupied by the physician. If more than custodial care is to be given mental patients, there must take place in the psychiatric hospital a general increase in the physician per patient ratio. Individual treatment through the psychotherapeutic approach has many profound ramifications for which there is neither counterpart nor substitute. Group therapy procedures are next in importance and effectiveness.[9,11] They certainly will be used more in the future.

The insulin and electric shock therapies have their place.[19] Electro-shock therapy is specific for some of the involutional psychoses and many of the depressions. The insulin method is often preferable in the schizophrenias. Not a panacea for mental illness, shock treatment is very effectively employed as a rapid means of making a psychotic patient accessible to individual or group therapy. Future research in the basic sciences may be expected to supply additional answers to many questions obscured in the enigma of mental illness. Narco-synthesis, having many limitations, has been used by civilian and military neuropsychiatrists, with good results.

The educator might say, "All work and no play makes Jack a dull boy." The financier and the economist counter by stating, "All work and no play makes jack." The psychiatrist, on the other hand, believes, "All work and no play raises hell with Jack." The profitable expenditure of spare time in pursuit of hobbies and recreation if learned at all must be learned early. As English and Pearson[8] have clearly brought out, middle age and retirement problems require that we plan and prepare in advance. Recreational therapy at times is productive of results when other measures fail. In the neuroses an early and fundamental symptom is the impairment of capacity for work, whereas in the psychoses, there is severe impairment of working capacity. Many a patient has sustained an acute mental breakdown as a result of emotional conflict and increased work and responsibility. Therefore, is it surprising that the patient who is mentally sick cannot at first interest himself in work when he feels that it has been a factor in precipitating his breakdown? Active recreation may include a wide variety of any of the sports.

The patient who is in mental turmoil often needs the private counsel of a clergyman or chaplain who is able to give comfort and reassurance for the soul. Most clergymen are interested in mental illness, but their comprehension of it is meager. The psychiatric training center could well consider giving training to undergraduate clergyman. Such a plan would envisage an arrangement with the seminary whereby young clergymen would spend several months on an in-hospital basis at the training center. Thus the clergyman, alert to the symptoms of mental illness, would become invaluable to his community and to his parishoners. We must remember, however, that religious assurances alone constitute suppressive and not expressive therapy. It may be said that the help and assistance which the clergyman can give are largely determined by his comprehension of mental illness.

The skilled psychiatric social worker has established herself as an indispensable link in complex treatment and rehabilitation of the psychiatric patient. We must train as quickly as possible a great many more of them. The skill and judgment of the psychiatric social worker, in counsel with the psychiatrist, is a determining factor, first, in the placement of the patient back into the community, and second, in the supervision of his continuing adjustment.

It is a fact that in physical illness emotional factors are very often neglected, and the converse is also true—that in mental illness, physical disease

is overlooked or neglected. The infectious diseases, syphilis and tuberculosis are vulnerable for attack. Many mental hospitals are teeming with pulmonary tuberculosis. Every patient admitted to a general or a mental hospital should have a Wassermann blood test and a chest x-ray. The patient having far-advanced pulmonary tuberculosis, with little chance of recovery, may be isolated, while the patient with a minimal lesion can be treated and cured. Doubtful cases, registered in a tickler file system, should be kept under continuous scrutiny and again x-rayed at short intervals.

The responsibility of the general and the psychiatric hospital does not end with the diagnosis and reporting of tuberculosis and syphilis. Outside contacts, direct and indirect, should be investigated. At this point, progressive state departments of health will be eager to be of service. The tracing of infectious disease contacts, especially syphilis, is highly technical work. The utmost in patience, tact, perseverance and skill is brought into play by the trained epidemiologist and his co-workers. The field work is usually done by the public health nurse, trained in epidemiological procedure. Follow-up work in syphilis and tuberculosis is imperative and fruitful because of the number of positive contacts frequently discovered. It is not uncommon to find more than a score of positive contacts traceable from a single case of syphilis. Likewise in tuberculosis investigation, the epidemiologist is never satisfied until he has determined from whom the patient received his infection and to whom he may have given it.

Research in Psychiatry

Had it not been for the efforts of Lister, Banting and Best, Freud, Cushing and many others, medicine would not be what it is today. Psychiatry has been designated as the oldest art and the newest science in medicine. Make no mistake, no specialty embraces a greater potential, and none offers a greater stake, than does psychiatry, within the entire field of medicine.

Psychiatry as a field for medical research is without equal. Psychosomatics are rich and inviting. The old age psychoses are challenging and their apparent increase demands investigation and research. Countless other psychiatric entities beckon the research investigator. Success in psychiatric research, as in other endeavor, is dependent upon sufficient finance, physical facilities and the mobilization of brains. Legislators must realize that with the decline of private philanthropy the financial burden of research must be borne by the taxpayer.

Summary and Conclusions

A presentation of the most pressing public health problem of our time has been set forth and effective measures necessary for solution have been described. Out of the present state of flux, and as result of research, there will emerge other methods of treatment for the mentally ill. Medicine in general and psychiatry in particular are anything but static. Mental illness is preventable and curable, and that which can be accomplished is infinite.

Federal, state and local health agencies are intensely interested in mental health and they are in a unique position to render service through health educational methods and field work. The time is not far removed when preventive mental medicine will become the most important phase of school health work.

It is the sole responsibility of the medical profession to provide sorely needed leadership in the campaign against mental illness. Present medical men, trained in the organic tradition of medicine, the "either-or" concept, are slow to recognize and accept the psychic component in medicine. It is high time that we begin to train the medical student away from the "either-or" concept and toward the "both-and" concept.

The significant experiences of Weiss and English,[29] with medical students in Philadelphia, set forth in their textbook "Psychosomatic Medicine," should compel our medical schools to take cognizance. To the Long Island College of Medicine goes credit for the first Department of Psychosomatic Medicine to be established in a medical school.

There will probably be many who will read this paper and conclude that a psychiatric program, such as the one outlined, while desirable and productive of results, is economically prohibitive. Is the taxpayer not already overburdened? Without giving careful cognizance, they answer in the affirmative. Granted, the burden of the taxpayer is heavy, and, unfortunately, taxation levies will not return to the level of the pre-industrial revolution era. Indeed, taxes must needs increase in proportion to the complexity of modern civilization. The inescapable truth is, that in one way

or another, the taxpayer, regardless of his wishes, must and will pay the costs dictated by mental illness. Of the taxpayer's dollar, the Commonwealth of Massachusetts now expends more than seventeen cents for the care of its mentally ill and this amount is insufficient. John Citizen is emerging from the citadel of rugged American individualism and he is determined to enter into a new era. He is eager to improve upon his physical and mental health. He believes that financial costs and other important considerations outweighing economics can best be solved by meeting the situation squarely, because in the end, good treatment will be the least expensive.

Thomas Parran,[28] in his authoritative book on syphilis, "Shadow on the Land," cited a most interesting personal experience. The Surgeon General of the United States Public Health Service, when in a large midwest city, chanced to observe an acquaintance afflicted with syphilis of the central nervous system. This man, enclosed in a fever therapy cabinet, was described as anything but comfortable. Dr. Parran commented that, ironically, here was a prominent man of comfortable economic means, well known to him, who had vehemently opposed the passage of the Social Security Act and its public health provisions. Many a taxpayer unconsciously entertaining the philosophy, "it can't happen here," has sustained mental illness. Where or whom mental illness will strike next, no man can say. It may be stated forcefully that the attitude of many has been softened because the catastrophe of mental illness has struck either family or friend.

It is doubtful that there is any psychiatrist who in his state hospital experience has had no alternative other than to explain to an anxious relative that Betty's illness is probably hopeless. It will not make this relative feel easier if the physician further reiterates that had Betty been given earlier specific treatment, her illness might have been prevented, arrested or cured.

References

1. Aring, C. D., and Bateman, J. F.: Nurturing a national neurosis. J.A.M.A., 109:1092, (Oct.) 1937.
2. Billings, E. G.: The general hospital; its psychiatric needs and the opportunities it offers for psychiatric teaching. Am. J. M. Sc., 194:234, 1937.
3. Boas, E. P.: The Unseen Plague—Chronic Disease. New York: Augustin, 1940.
4. Bryan, Wm. A.: Administrative Psychiatry. New York: W. W. Norton Co., 1936.
5. Dublin, L. J., and Lotka, A. J.: Twenty-five Years of Health Progress. New York: Metropolitan Life Insurance Co., 1937.
6. Dunbar, Flanders: Psychosomatic Diagnosis. New York: Paul B. Hober, 1943.
7. English, O., and Pearson, G. H. J.: Common Neuroses of Children and Adults. New York: W. W. Norton Co., 1937.
8. English, O. S., and Pearson, G. H. J.: Emotional Problems of Living. New York: W. W. Norton Co., 1945.
9. Fiddler, J., and Standish, C.: Observations noted during course of group treatment of psychoses. Dis. Nerv. System, 9:24, (Jan.) 1948.
10. Flemming, A. G.; Marsh, L. C., and Blaskler, C. F.: Health and Unemployment: Some Studies of Their Relationships. Toronto: Oxford University Press, 1938.
11. Gifford, S., and Mackenzie, J.: A review of the literature on group treatment of psychoses. Dis. Nerv. System, 9:19, (Jan.) 1948.
12. Halliday, J. L.: The rising incidence of phsychosomatic illness. Brit. M. J., 2:11, 1938.
13. Halliday, J. L.: Social pathology. Brit. M. J. 2:1012, 1938.
14. Halliday, J. L.: Psychological factors in rheumatism; preliminary study. Brit. M. J., 31:167, 1938.
15. Halliday, J. L.: Psychological approach to rheumatism. Proc. Roy. Soc. Med., 31:167, 1938.
16. Hedley, O. F.: An etiological study of 450 cases of heart disease. Pub. Health Rep., 50:1127, 1935.
17. Heldt, Thos. J.: The functioning of a division of neuropsychiatry in a general hospital. Am. J. Psychiat., 7:459, 1927.
18. Heldt, Thos. J.: The treatment of mental diseases in a general hospital. New York State J. Med., 30:63, 1930.
19. Kalinowsky, L. B., and Hoch, Paul H.: Shock Treatment and Other Somatic Procedures in Psychiatry. New York: Grune and Stratton, 1946.
20. Masserman, Jules H.: Mental hygiene in a world crisis. Dis. Nerv. System, 10:213, (July) 1948.
21. Menninger, K. A.: Emotional factors in hypertension. Bull. New York Acad. Med., 14:198, 1938.
22. Menninger, Karl A.: The place of the psychiatric department in the general hospital. Mod. Hosp., 23:1, 1924.
23. Menninger, Karl A.: The future of psychiatric care in hospitals. Mod. Hosp., 64:31, (May) 1945.
24. Menninger, K. A., and Menninger, W. C.: Psychoanalytic observations in cardiac disorders. Am. Heart J., 11:10, 1936.
25. National Safety Council: Accident Facts. Chicago: The National Safety Council, 1942.
26. Parran, Thomas: Shadow on the Land. New York: Reynal Hitchcock, 1937.
27. Sandy, W. C.: What the general hospital offers to the psychiatric patient. Mod. Hosp., 25:189, 1925.
28. Weiss, E.: Recent advances in the pathogenesis and treatment of hypertension: a review. Psychosom. Med., 1:180, 1939.
29. Weiss, E., and English, O. S.: Psychosomatic Medicine. Philadelphia: W. B. Saunders Co., 1943.

MSMS

PRESIDENT'S ADDRESS

(Continued from Page 50)

constructive ideas to defend America against the expected renewal of pressure to create in our country the welfare state.

Times have changed. We are living in a world of flux. Our United States is not now a country of isolation, but has been precipitated into world affairs. It must assume and it is assuming the leadership of the world in nearly every field of endeavor. Just so, the medical profession of this country must assume its role of leadership, both in the scientific and in the attendant economic and political fields.

However, we cannot do this alone. By providing knowledge and offering co-operative assistance to our citizens, by carrying an *honest* message to them, and by urging them to voice their opinions actively, all of us together can hold fast to our American way of life and make it grow to meet the needs that constantly arise. Only in this way can we preserve for each American individual the right to private initiative, private enterprise, and personal planning for the future. We still can choose —if we *voice* our choice. Shall it be the welfare or the American state?

The Place of Psychiatry in Industry

By L. E. Himler, M.D.
Ann Arbor, Michigan

THE URGENT NEED for betterment of human relations in industry is widely recognized, but the extent to which psychiatric knowledge and methods could be constructively used is only beginning to be realized and accepted. During World War II, both psychologists and psychiatrists were called upon to assist in carrying out plans for the improvement of selection procedures, in developing supervisory training programs, and in furthering various activities which were aimed at maintaining employe morale at a high level. The draft examinations aroused concern among industrialists as among the public over the great incidence of neuropsychiatric disabilities among men of military age. Subsequent discussion of anticipated problems in connection with the re-employment of neuropsychiatric dischargees and casualties likewise created apprehension, but the true relationship of this situation to industry was neither understood nor adequately investigated, and the ill-advised publicity with which it was attended did more in the end to discredit than to encourage the assimilation of a sound psychiatric approach.

But the problem of handling psychiatrically handicapped workers is not a new one; it was not created, nor was it materially increased, by the war. It has always existed, and industry has always had to deal with it in some way, although never entirely satisfactorily or adequately from the standpoint of all concerned: management, labor, the individual, and the community. In industry as in most communities, standards for services provided for mental and emotional health fall far below those maintained with respect to physical health. Yet today there are no problems in industry more urgent than those directly and indirectly related to individual and group mental health, whether considered from the standpoint of the immediate incidence of adjustment difficulties which individuals manifest on the job, or that of the long-range relationships existing among working teams and between their leaders on the sides of management and labor.

The end of the war brought a rather sudden close to many of the promising undertakings in the field of industrial mental health on the part of psychologists and psychiatrists. It is a commentary on the type of expediency for which modern industry is sometimes noted, that when the cost-plus basis of operations was terminated, these activities fell into the so-called "frill" class, and on the basis of what is considered to be economy, were among the first to be either eliminated or drastically curtailed. Today there are scarcely more than a half-dozen psychiatrists employed by industry or labor on a full-time basis. A somewhat greater number of consultants are engaged on a part-time basis, but it is obvious that these supply only the barest fraction of the real needs. So far as available personnel with medical training is concerned, therefore, the brunt of the responsibility for handling psychiatric problems falls back on the industrial physicians and general practitioners who serve industry and labor. The competence of these men in this field varies through a wide range from those who have a limited, purely organic and "surgical" concept of the physician's function, with only a minimal interest in emotional factors, to those who have acquired a keen understanding of human nature and whose management of emotional problems and borderline psychiatric material equals if not surpasses that of some fully trained, qualified psychiatrists.

Before initiating or extending psychological or psychiatric programs for industry, it would be well to study the preparation, background, understanding, motives, and objectives of both the employer and the specialist who assumes responsibility for directing activities in the human relations field. As after the first world war, many self-styled experts and purveyors of pseudo-scientific devices are appearing on the scene. Business men who are eager to apply the newer techniques of the mental sciences to their particular employe and labor relations problems unfortunately have no satisfactory yardstick with which to measure the merit of the many attractively-packaged panaceas constantly being offered. Reputable psychologists, psychiatrists, and psychiatrically oriented industrial physicians do not promise cure-alls, but their clinical background gives them the soundest over-all equipment and experience for continuing needed studies to im-

Presented at the eighty-fourth annual meeting of the Michigan State Medical Society, September 23, 1949, at Grand Rapids, Michigan.

prove selection, placement, supervision and treatment of employes having some degree of mental or emotional handicap, and for teaching the techniques of better interpersonal relationships on all levels of industrial organization.

From the outset it should be clear that any plan for the extension and application of psychologic and psychiatric knowledge and methods cannot be ordered or superimposed by force or by directives from higher authority. The men who represent these disciplines must first win the support of key people in existing executive, personnel, medical, and labor relations departments who are already doing work in human relations. We cannot side-step the fact that there is still much groundwork to do in educating industrialists as to the unique value of our contribution, and in overcoming prejudices, blind-spots, and resistances. One of the most important tasks which industrial psychiatry still faces is that of explaining itself to those it can so effectively serve. Far too many industrialists still cling to the traditional belief that psychiatry benefits only the obviously mentally ill, and that it does relatively little to conserve the mental fitness of average normal individuals, much less actually to increase the productive capacity of people in working groups.

Fortunately most experienced physicians in industry are aware of the potential contributions which psychology and psychiatry can make, not only on the practical level of treating individuals in need of counseling, but on the preventive and policy-making levels as well. Specialists, working in collaboration with them, must teach and provide clinical training, both formally and by practical demonstration in specific instances, which will convincingly portray the value of a psychotherapeutic approach to industrial interpersonal relations. Painstaking efforts are required to overcome the resistance of certain men in top positions who are unaware that they create more problems than they solve by using coercive tactics which violate the principles of mental health. Some who have "come up the hard way" and whose training was exclusively in the fields of engineering, accounting, or law, are peculiarly impervious to a new, non-authoritarian approach to human relations.

It goes without saying that the medical department should be one of the major focal points within industry from which the spirit of constructive human relationships constantly radiates. Striking evidence of this need is given in Dr. William J. Fulton's article entitled, "Industrial Medical Potentials: A Time and Job Analysis of Medicine in Industry," which was published in the journal of *Industrial Medicine* for July, 1949. Fourteen years of experience and observation form the basis of Dr. Fulton's unqualified statement that "the human factor, not the health factor, is the underlying cause of most accidents, complaints, and personnel problems." True physical causes for complaints brought to the medical department were found in less than 50 per cent of the patients. Another significant finding is that 85 per cent of direct medical services are utilized consistently by only 30 per cent of the employes. This 30 per cent group includes the large majority of substandard workers with emotional, neurotic, psychosomatic, and psychiatric problems. Even though these individuals use up over twice as much time of physicians and nurses as average employes do, any curtailment of service to them would inevitably increase their already high rate of absences, minor accidents, dispensary visits, unsatisfactory personnel contacts, and incidence of grievances. Inadequate handling of the problems of this minority group would in the end still further reduce the medical care available to the other 70 per cent of industrial society.

But Dr. Fulton does not imply that the services of psychiatrists or psychologists as specialists are needed to care for the upwards of 60 per cent of employes whose complaints are based on a prominent "functional" (i.e., psychogenic) element. What is needed is indoctrination of more physicians, nurses, and employe counselors with the basic principles and techniques of psychotherapy to the extent that such measures are needed and are practical within the industrial framework. In a series of 100 employes referred to me during the war, I found that three-fourths of them could have been adequately cared for by a psychologist or counselor with the proper personality and training, and over 95 per cent would ordinarily be capably handled by the psychiatrically oriented industrial physician. Only 3 per cent were in need of advanced psychiatric assistance which fell outside the province of industry's responsibility, and which called for referral to a private psychiatrist. Thus even though the majority of employes coming to the medical department are psychologically rather than physically ill, the qualified physician and his properly trained aides

should be competent in caring for all but a small minority.

When viewed in the broadest possible perspective, the functions of mental health specialists in industry, whether psychiatrists, psychologists, or trained counselors working under their direction, include a constantly expanding range of both clinical and preventive activities. The clinical services to individual employes which have psychological and psychiatric implications can be listed as follows:

1. Appraisal of those factors in the individual's personality which bear directly on his fitness or unfitness for work. This constitutes a part of both the employment interviewer's and the physician's preplacement examination procedure.
2. Recognition of neuropsychiatric conditions in their earliest manifestations, not only in applicants for work, but also as these may make their appearance at any time after employment. Here are included psychoses, neuroses, neurosyphilis, alcoholism, epilepsy, and psychopathic personality.
3. Evaluation of neuropsychiatric factors in posttraumatic conditions covered by workmen's compensation laws.
4. Determination of the degree of employability or re-employability in postpsychotic states (e.g., recovery after manic-depressive episodes, involutional melancholia, and certain instances of dementia precox).
5. Consultation when and where required regarding the placement, transfer, promotion, or progress of individuals possessing valuable skill, but who exhibit potentially troublesome personality handicaps or deviations in their interpersonal relationships.
6. Assessment of emotional factors in accidents and absenteeism.
7. Application of direct psychotherapy in selected individual cases as may be practical within the limitations of the industrial setting.

It should be emphasized that the purpose behind steps leading to better recognition of neuropsychiatric disorders is not merely the elimination of all such persons as might be deemed to belong to the so-called misfit class. This is a misconception shared by many who associate the work of psychiatry with the exclusion of the mentally ill from society, and who think of industrial psychiatry as fulfilling a similar arbitrary function. Actually this is only a relatively small, negative aspect of selection which takes place in a more arbitrary, hit-and-miss fashion without psychiatric understanding than with it. The much more important positive task relates to the proper placement of individuals with some degree of emotional handicap who when properly placed and supervised can become as useful employes as those who are physically handicapped. Emotionally handicapped individuals have just as much right to work as the physically handicapped, and better understanding of their unique personality reactions should be the means of more effective occupational adjustment, not denial of the opportunity to work. Placement problems in these instances are usually more complex and delicate, since the human relations aspects rather than ability, skill, or type of work are of more determining importance in success or failure of employment. Here the selection process must extend to supervisors who have the requisite skills for handling such individuals, especially in the initial stages of their employment.

It has become increasingly clear that if psychiatry in industry is to fulfill a truly preventive function, it must extend its influence beyond the limited area of responsibility generally delegated to industrial medical departments. Years ago, Dr. V. V. Anderson, author of the first and still the only textbook devoted exclusively to this field, stated that the task of psychiatry in industry is much less that of providing clinical services for individual problem workers than it is to integrate its techniques with all personnel and supervisory procedures connected with the "employment case history" from inception through all stages to discharge or retirement. Perhaps the highest contribution which the psychiatrically oriented physician can make relates to both quantitative and qualitative aspects of all interviewing, testing, selecting key men for promotion, and counseling on all levels. The continuing education and training of executives, foremen, personnel administrators, and labor leaders, who are all in effect practitioners of human relations, involves no small measure of psychiatric indoctrination.

The approach to industrial human relations problems which the psychiatrist uses himself, and which he can to a considerable extent teach to others, can for practical purposes be considered as an adaptation of interviewing techniques. Interviews in the industrial setting tend to fall into three general classes: those which have to do with an exchange of factual information, those which involve training and education and hence require some application of the laws of learning, and those on the more complex therapeutic level which involve subjective emotional reactions rather than purely objective facts. Interviews regarding ef-

ficiency, attitudes, transfers, layoffs, promotion, rate of pay, or discipline may at any point require therapeutic skills for their effective solution. It is obvious that a higher type of counseling is required in the handling of problem employes, and individuals with complaints, dissatisfactions, grievances or repeated personality clashes. Grievances should be approached from the standpoint of both their manifest and their latent content; it is the latter which reveals the true motivation in individuals who are grievance-prone. Interviews whose central topic concerns symptoms of illness, even when this is apparently entirely physical, often require a similar inquiry into motivational factors. These of course fall more directly into the province of the physician and the trained technicians working with him. As has been mentioned, fully half or more of the interviews in the medical department involve the interplay of emotional forces and conflicts underlying the physical focus.

The time has come when psychiatrists, psychologists, and psychiatrically trained physicians can no longer remain aloof from social conflicts in the field of labor relations whose outcome depends to such an alarming degree on emotional rather than factual issues. Specialists in human relations must make available to industry their ability to analyze and alleviate the psychological factors which promote work stoppages and strikes. A strike represents a failure of solution of conflict, and has a status very much like the regressive symptoms which appear as a manifestation of a psychoneurotic reaction in an individual. The component forces leading to a strike are accentuated when they are overlooked, ignored, or mishandled after they break into the open. The proper approach is a preventive one which studies the emotional factors involved in individual and group reactions before they reach the stage of hostility and aggressive conflict.

Along with the clinical, advisory, and educational functions which have been mentioned, industrial psychiatry also has a research interest in the causes, types, setting, modifiability, and prevention of problems in industry involving personality and emotion. Much more study is needed of the factors underlying unreal beliefs, opinions, and attitudes which lead to destructive behavior and are consciously and unconsciously involved in the frequent distortion of communications in large organizations. Further analysis is needed of the feelings of insecurity, frustration, and disorientation which are incident to the introduction of new technologies. Studies must be made of the determinants underlying human motivation in relation to work, conflict, and co-operation, with a view to a better evaluation of the "rules of thumb" now used by various leaders in industry and labor organizations. The psychiatric case study method, applied to normal and successful employes, can aid in establishing a baseline and frame of reference for studying the poorly adjusted individuals. Such investigations will in turn point the way to a constantly wider application of the concepts of psychiatry in industrial human relations.

Grateful acknowledgment for help in the preparation of this paper is hereby made to the following members of the Committee on Industrial Psychiatry of the American Psychiatric Association: Drs. Matthew Brody, Temple Burling, Ralph T. Collins, Alexander Leighton, and George N. Thompson.—L. E. HIMLER, M.D., *Chairman.*

MSMS

EXPERIENCE WITH ROUTINE Rh TYPING IN OBSTETRICS

(Continued from Page 58)

5. Diamond, S. K., and Abelson, N. M.: The importance of Rh inhibitor substance in anti-Rh serums. J. Clin. Investigation, 24:122-126, (Jan.) 1945.
6. Diamond, L. K., and Abelson, N. M.: The detection of Rh sensitization: evaluation of tests for Rh antibodies. J. Lab. & Clin. Med., 30:688, (Aug.) 1945.
7. Fisher, R. A., and Race, R. R.: Rh gene frequencies in Britain. Nature, 157:48-51, (Jan.) 1946.
8. Howard, J., et al: The clinical significance of Rh antibodies (Rh agglutinins and blocking antibodies) in the sera of Rh negative mothers. Am. J. Obst. & Gynec., 53:569, (April) 1947.
9. Hunt, A. B.: The Rh factor in abortion. Am. J. Obst. & Gynec., 53:467, (March) 1947.
10. Javert, C. T.: Further studies on erythroblastosis neonatorum of obstetrical significance. Am. J. Obst. & Gynec., 43: 921, (June) 1942.
11. Kariher, D. H.: On prophylaxis of hemolytic disease of the newborn. Am. J. Obst. & Gynec., 54:1, (July) 1947.
12. Landsteiner, K., and Weiner, A. S.: On the presence of M. agglutinogens in the blood of monkeys. J. Immunol., 33:19, (July) 1937.
13. Levine, P., and Stetson, R.: Unsual case of intra-group agglutination. J.A.M.A., 113:126, (July) 1939.
14. Levine, P.: Prevention of unintentional isoimmunization of the Rh negative female population. J.A.M.A., 128:946, (July) 1945.
15. Levine, P.: The present status of the Rh factor. Am. J. Clin. Path., 16:597-620, (Oct.) 1946.
16. Overstreet, E. W., et al: Does Rh isoimmunizations cause early abortions? Am. J. Obst. & Gynec., 54:235, (Aug.) 1947.
17. Page, E. W.; Hunt, M., and Lucia, S. P.: The antepartum prediction of hemorrhagic disease of the newborn. Am. J. Obst. & Gynec., 52:794, (Nov.) 1946.
18. Race, R. R.; Taylor, G. L.; Cappel, D. F., and McFarlane, M. N.: The Rh factor and erythroblastosis foetalis: an investigation of 50 families. Brit. M. J., 2:289, (Sept.) 1943.
19. Sacks, M. S.; Kuhus, W. J., and Jahn, E. F.: Studies in Rh-isoimmunization in pregnancy. 54:400, (Sept.) 1947.
20. Spalding, H. C.: Erythroblastosis in infant of primigravida. Am. J. Obst. & Gynec., 54:1052, (Dec.) 1947.
21. Weiner, A. S.: Pathogenesis of congenital hemolytic disease (erythroblastosis fetalis). I. Theoretical considerations. Am. J. Dis. Child., 71:14-24, (Jan.) 1946.
22. Weiner, A. S.: Congenital hemolytic disease and erythroblastosis fetalis: two disease syndromes. New York State J. Med., 46:912, (April) 1946.
23. Weiner, A. S.: Recent developments in the knowledge of the Rh-Hr blood types: tests for Rh sensitization. Am. J. Clin. Path., 16:477, (Aug.) 1946.

Iatrogenicity in Medicine

By Franklin G. Ebaugh, M.D.
Denver, Colorado

IATROGENIC ILLNESSES are those disorders unwittingly induced in the patient by the physician, based on the physician's examination, manner and discussion.[1] This paper will be limited to the iatrogenic role of emotion in disease.

Two thousand, five hundred years ago, Socrates chided the Athenian physicians for their organistic medical attitude and expressed his belief that the body could not be cured without treating the mind; that the cure of many diseases was unknown because physicians were ignorant of the whole. This rebuke is now accorded the stature of a truism. Medicine also further recognizes that a physician's unawareness or misunderstanding of the role emotion plays in disease may not only prevent cure but may precipitate and perpetuate illness.

Iatrogenicity usually results from: (1) failure to recognize the existence of emotional factors in illness, (2) inability to treat minor emotional disorders if recognized, (3) lack of awareness of the role which the physician's feelings, attitudes, and behavior play in the cause and cure of sickness.

Failure to Recognize Existence of Emotional Factors in Illness

The genesis of these three factors is largely rooted in the limitations imposed by the Virchovian concept that equated disease to cellular pathology. This structural orientation, utilizing anatomical and histological techniques, revealed the organic architecture of disease. The application of physics and chemistry clarified the functional interrelationships of the body parts. This structural approach led to the concept of the human organism as a machine in which all disorders could be explained either as a nutritive defect or a fault in one or more of the component parts, organ, tissue or cell. Diagnosis became synonymous with identification of the deficiency or faulty part. Therapy based on these premises became more or less rigid, static and mechanical, and it was assumed that correction of the deficiency in body needs, repair or elimination of the faulty part would result in a cure.

The fallacy of this approach to the cause and cure of disease lay not within the structure of this concept, but without; i.e., this mechanical approach did not take into consideration such important factors as: (1) the psychological aspect of the individual and the inseparable relationship between psyche and soma, (2) individuality *per se,* (3) environment. This restrictive, organistic concept of illness necessarily failed to answer such vital questions as: (1) How can the illness be prevented? (2) Why did the patient become ill at this time? (3) Why is the patient reacting in this particular manner to his illness?

From time immemorial, environment has been credited with causing the ills of man, but these observations were distorted and hopelessly intermingled with religion, superstition and magic. In discarding these animistic and metaphysical philosophies as being nonscientific, the importance of man's surroundings as a factor in disease was correspondingly shunned and neglected. Pasteur's discoveries reawakened an awareness of the importance of environment in the cause and cure of disease and indicated the scientific validity of such observations. However, translation of these implications to admission that psychological factors in the environment could also produce disturbances in the human organism was not immediate.

Resistance to such a concept was based on the criticism that phenomena which could not be measured or reproduced according to rather rigid criteria could not be accepted as being scientific. The past observations of emotion had always been so closely allied with the occult and esoteric that the status of psychiatry as a science was long delayed. These two factors long denied psychiatry a legitimate place in the circle of science. Final admission of the scientific validity that psychological factors could produce disturbance in the organism, plus the observation that there were individual variations in reaction and behavior in an identical environment, led to the ultimate concept that in illness, the "cause is twofold and lies both in the nature of the individual and in the nature of his environment at a particular point in time."[2]

The most appropriate medical action, therefore, is not limited to concern with a "faulty part" of the body, but is "concerned primarily with the measures designed to: (a) alter or prevent char-

From the Colorado Psychopathic Hospital, University of Colorado Medical Center.

Read at the eighty-fourth annual session and Postgraduate Conference of the Michigan State Medical Society, Grand Rapids, Michigan, September 23, 1949.

acteristics of the person known to be causal, and (b) alleviate or remove factors of the environment known to be causal."[2]

I have prefaced my discussion with this historical genetic preamble on the cause and cure of disease because therein lies many an iatrogenic root. This narrowed focus of attention tends to preclude an awareness of the individual as such, and his inter-environmental relationships. Such a preclusion eliminates awareness and understanding of the existence of emotional factors in illnesses.

Let us restate the fact that the most common cause for medically induced illness is failure to recognize the existence of emotional factors involved. Years of pregraduate and postgraduate teaching have convinced me that this failure reflects a major defect in basic medical education. Even now, our medical orientation is largely limited to the mechanistic viewpoint to which I have just referred. To repeat, this narrowed focus of attention tends to preclude the doctor's awareness of the individual's environmental relationships. Without this awareness, the existence of emotional factors goes unperceived, and their relationship to sickness unnoticed and not understood.

The traditional form employed in taking a medical history clearly reflects this mechanistic philosophy. It gives you an excellent concept of the status of the body parts, some idea of function, usually limited to a system concept, but tells you nothing about the individual *per se,* his environmental relationships, or his feelings. For example, a history of intestinal dysfunction alone does not suggest hostility, and it certainly does not tell you that the intestinal complaints may be a functional reflection of acute marital discord.

Not infrequently, on being called into consultation, I find a patient who literally is eager to relate the distress of an unrequited love, anger over an allegedly philandering husband, or fear of carcinoma. My colleagues, upon being advised of the rather obvious immediate cause for the patient's anxiety, are given to asking, "How did you find that out?" strongly implying what magic or what sorcerer's brew had I used.

The formula is: *I listen to the patient.* It is important to listen carefully to the heart. It is equally important to listen to the patient. It is important in doing a complete examination to palpate the abdomen. It is also important to feel what the patient is feeling. I do not mean that in all cases the patient will immediately reveal the area of his conflict through the simple expedient of listening. Not infrequently, however, he can, and will, if but given the opportunity.

If the pursuit of pathology is exclusively oriented toward the discovery of the culprit organ or tissue, the patient, in deference to your professional rank, forsakes his amateur opinions and joins you in the pursuit of the organic will-o'-the-wisp, through the laboratory, into the roentgen room, as a bewildered partner in a tag dance with multiple specialty consultants. Then midnight, and alas, the organic glass slipper does not fit. The patient is discharged wearing sackcloth and ashes variously labelled: "Medical examination, no pathology found. Ill defined condition, no cause determined." Not infrequently some innocent anomaly or non-causal pathology uncovered in the organic witch hunt is falsely honored and burned at the diagnostic stake. Lo, the tipped uterus, the flat foot, the infected tooth, the evil adhesion! Repartee at times becomes difficult when the pathologist comments on that chronic appendix, "Another interesting specimen, normal you know." Before crossing the diagnostic "track," listen to—as well as look at—the patient.

Other issues must be considered if the failure to recognize the existence of emotional factors in disease is to be fully understood. Although the nonscientific shadows from which the science of the psyche arose now belong to the historical past, the stigmata of being nonscientific still becloud professional as well as lay feelings. Physicians tend to avoid materia psychologica for fear of being compromised in the eyes of their confreres. As a reflection of these feelings, I have often noted the nonchalant ease with which the mistake of misidentifying and mistreating an emotional disturbance as an organic disorder is accepted, in contrast to the derision and opprobrium which greet the erroneous diagnosis of tissue pathology as a psychological disorder.

The failure to accept psychiatry and the allied sciences, the feeling that psychiatry constitutes a somewhat difficult, rather esoteric, and even peculiar sister specialty, is also due in part to certain growth characteristics, even defects, within the specialty itself. Psychiatric terminology has produced a barrier that makes the transfer of ideas difficult to the uninitiated, often obscuring the otherwise simple and obvious. This tendency to speak a "foreign tongue" is not conducive to understanding. Partly because of the tremendous

need, and in part due to the adolescent boasting of a young specialty proclaiming its place in the circle of science, it has been called upon to fulfill, or has made, claims that it cannot yet meet. Failure to meet all expectations has resulted not infrequently in a complete denial of the very real contributions it has to make and irrational rejection of the importance of emotional phenomena in disease. Any science in its infancy somehow tends to attract individuals whose personality problems in themselves may be the motivation for this interest in the different and the strange. The very nature of psychiatry creates a moth-like attraction for those who come consciously to cure, but unconsciously to be cured. As the questionable appeal of the mysterious has dropped away and with awareness of these factors in selection of candidates for training in the specialty, this situation is disappearing. However, I should like to comment that irrespective of these personality traits, many such men have made major contributions in the field, but public relations were neither fostered nor the science accepted the more kindly because of their own peculiarities and eccentricities.

Because of the tendency to see only that which is acceptable, these common scotomata reduce the professional field of vision for emotional factors. I would not belabor the importance of these blind spots if it were not for the fact that they obscure such a tremendous area of clinical importance. Since every third patient who comes into your office will be suffering primarily from an emotional disorder, and in the next patient whom you attend these factors will be of equal importance to existent organ pathology, correction of faulty vision in this area is not then to concern ourselves with minutiae or the trivial.

How does failure to recognize the existence of psychological issues in an illness cause or promulgate illness? This question can be more accurately phrased, "How can misdiagnosis cause sickness?" Persistent professional preoccupation with and the pursuit of the "faulty part" imply clearly to the patient that in view of his complaints you feel he must be host to such a defect. Now, in addition to whatever concern was present before, you have created another source of anxiety *de novo,* a threat to his body integrity. The patient is now enjoying the dubious pleasure of iatrogenic anxiety, which under your guidance before long will become affixed to the organic "red herring" for which you have been searching. Typical "red herrings" are functional physiological disturbances, secondary to the anxiety so created, or some innocent anomaly or non-causal pathology dragged up from the depths by the diagnostic dragnet. Now original anxiety, plus that professionally induced, typically become affixed to whatever system has been circumstantially incriminated by a focus limited to organ evaluation. Spontaneous or situational resolution of the original stress responsible for the patient's initial complaints does not result in a cure, for now the patient is preoccupied with whatever organic scapegoat was constructed by the physician's exclusive attention to physiological phenomena. In emotional disorders misidentified and mistreated as organic diseases, the tendency is not toward recovery but toward chronicity.

Misdiagnosis and mistreatment are common causes of iatrogenic illness when the unidentified and untreated etiology is psychological in nature. It is not necessary to give a stated misdiagnosis to constitute an actual misdiagnosis. Following a detailed and meticulous inspection of all organic crannies, you may advise the patient of your negative findings—but too late. Your scientific curiosity now may have been satiated, but the patient's anxiety remains. He will follow the implied organic die that has been cast from office to office, literally looking for something that cannot be found. At this point it becomes increasingly difficult to reverse these trends. The physician has supplied the patient with a certified rationalization for his anxiety which tends to reduce conscious recognition of it and further supplies a socially acceptable reason for whatever limitations the illness may impose upon him. I mention this because not only is there a feeling among the laity that emotional disorders are evidence of character weakness, a social disgrace, cause for shame and criticism, but you may have implied similar feelings by so assiduously avoiding the emotional sphere. Furthermore, the doctor may actually feel this way about disorders due to emotional disturbances. These feelings and behavior on his part are powerful fixing agents in iatrogenic illness.

Let us return to the assumption that you find no pathology explanatory for the complaint state and so advise the patient. What do you tell the patient? "There is nothing wrong with you," with the addenda, "It's your imagination," or to defend your prestige from the possibility that "something" will be uncovered by another colleague, "That

heart murmur—not important, probably will never bother you." "I don't find your condition really serious. I'm sure everything will work out all right (you hope)." Because of the trend engendered by your repeated negative examinations and your attitude, the patient frequently interprets this as, "He didn't find anything, but there must be something wrong (organically). Because he didn't tell me what it was, there must be something very seriously wrong." This mug-wumping technique of trying to be right in any event dismisses your patient with no other alternative than to continue further the distressing pursuit of organ pathology. Now the patient is typically off on an endless tour of iatrogenic medical shopping. Prejudiced by professional orientation to which I have just referred, the patient shops hopefully in the "organ department" but obviously never can find quite the right article. Many purchases are made but always with the inevitable discovery that the purchase is somehow never a satisfactory fit.

To reiterate, this endless quest is instituted by the doctor's original failure to note the emotional etiology for the patient's complaints and is misdirected by the total examination technique being exclusively oriented around the concept that all pathology must be equated to tissue pathology. It is apparent that the final pronouncement of "no pathology found" is not only untrue in the broader sense but in no way supplies an answer to the patient's need for assistance. Indeed, frequently, to the original need for seeking medical assistance is added the necessity of disproving his interpretation of such a pronouncement, i.e., "It is not my imagination," "I am not malingering."

It is apparent that hostility toward the doctor in particular, and medicine in general, results from such a situation. Financial depletion, enforced devotion to quackery, disillusionment and enmity toward legitimate medicine are often inevitable end results of this process.

Inability to Treat Minor Emotional Disorders If Recognized

Recognition of the presence of emotional factors in illness alone is not an answer to the patient's needs. What is or is not done after establishing a diagnosis is obviously of the greatest significance. Realistically, there is little difference between faulty and correct diagnosis if subsequently no treatment or inappropriate therapy is instituted. The previously mentioned factors responsible for the physician's failure to recognize the importance of emotion in disease also explain failure to treat or the inadequate treatment of the affective components of disease. This breach in the physician's therapeutic armamentarium not only fails to promote recovery but may prolong or incite illness.

The physician who feels lost when faced with a psychological disturbance frequently terminates his responsibility to the patient with the diagnostic pronouncement, "It's your nerves . . . You are neurotic . . . et cetera," without further definition of the patient's emotional disorder in common-sense terms which he can understand and accept. I do not mean to imply that you should avoid the use of appropriate and accurate technical terminology because of the false odiousness which has become attached to such terms as psychoneurosis, psychopathic personality, hysteria, et cetera, due to widespread misuse and misunderstanding. Indeed, it is a professional responsibility to eradicate these erroneous concepts not by avoidance but by appropriate interpretation of these diagnostic labels in terms of the individual patient's life experiences, so it will aid in the patient's understanding and acceptance rather than generate anxiety and apprehension. This applies not to psychiatric terminology alone but to the use of technical lingo in general.

Fear and anxiety are the bastard offspring of the unknown. Blessing a patient with a diagnostic label without an interpretation that is understandable to him may be a crippling phenomenon itself. Hiding your own ignorance behind the mask of scientific verbiage is more frequently depressive rather than impressive to the patient. A recent survey of the laity revealed that their most common criticism of the medical profession was that physicians did not explain their illnesses to them. This criticism clearly reveals the anxiety and resulting hostility provoked by the unknown, that is, leaving the patient "in the dark." If you underestimate your patient's capacity to understand, be assured that he will return the compliment.

The anxiety created by diagnostic labelling without explanation is frequently interpreted by the patient as libelling, and forces him to defensively deny the validity of the physician's diagnosis, particularly if the physician indicates that such a diagnosis precludes further treatment. This reaction is often further abetted by the doctor's

basic feeling that emotional disorders are the lot of the weak and depraved. The patient now seeks help elsewhere, but having learned that assistance is not forthcoming if emotional disturbance is revealed, he now confuses subsequent physicians with a distorting organic smoke screen. If the disorder requires specialty care, the manner of referral is important. Much in the same way that the manner of presenting a diagnosis of emotional disturbance may be helpful or harmful to the patient, so is the technique of referral implicit with the same potentials. If the referral is essentially a rejection of the patient with the inference, "I can't bother with you. You're crazy. Go see a psychiatrist," the patient may not be able to subsequently seek appropriate help because of the anxiety, resistance, resentment, and need to deny engendered by such an approach. These feelings may be so strong that the psychiatrist is contacted only for the purpose of disproving and denial. Needless to say, the physician who dupes the patient by not advising that he is being referred to a psychiatrist frequently constructs an impossible barrier to therapy. The other extreme in iatrogenic referral method, the pollyanna approach, that implies to the patient that a visit to the magician, a chant, a touch of voodoo and all will be well, predicates treatment with an illusion that often precludes actually helping the patient. It is obvious that medical schools should prepare all physicians to treat minor emotional disorders. It is fortunate that at the present time most schools are modifying their curricula in this direction.

Lack of Awareness of Role which Physician's Feelings, Attitudes, and Behavior play in Cause and Cure of Sickness

Recognition of the important role which the doctor's feelings, attitudes and behavior play in the cause and cure of illness is dependent upon acceptance and understanding of the role that emotion plays in the cause and cure of disease. In spite of this understanding, the doctor frequently neglects to evaluate, indeed is unaware of the effect which he, himself, has upon the patient. Time prevents even a cursory examination of the significance of the physician-patient relationship. In a broad sense I touched upon some of the factors in the preceding discussion.

Illness in general is a threat to the patient, increasing his dependency, i.e., the need and wish to be cared for. In general this feeling is present to a greater or less degree in all patients who come to a physician. Implicit in the doctor-patient relationship are the same constructs and feelings that exist between a child and parent. It is obvious to you that the parent's attitudes, feelings, and behavior are reflected in and have a great influence upon the child. Dependent upon the severity of the illness, the degree of helplessness enforced or provoked by the illlness, the duration and intensity of the doctor-patient relationship and the patient's previous experience with parental and authority figures, so will the doctor's personality play a role of varying importance in the course of the patient's reaction to his illness. Because of the infantile character of these phenomena, you are invested somewhat automatically by the patient with feelings rooted in earlier relationships with parents or other dominant figures. The wife's comment that her husband acts like a small boy when sick, the doctor's remark that the patient in Room No. 24 is behaving like a baby, the nurse's statement that the patient wants to be mothered, and the patient in extremus calling for his mother are everyday examples of this mechanism. It is therefore obvious that the doctor's own feelings, attitudes and behavior not only are powerful factors in curing but correspondingly may provoke or perpetuate sickness.

Let us inspect some of the more common feelings of the physician and note how the resulting attitudes and behavior may promote sickness rather than well-being in the patient.

Anxiety in the physician is transferred almost immediately to the patient and is usually increased markedly in the process. This transfer is dependent not only upon what is said, but frequently upon what is not said, the character of the voice, gestures, et cetera, i.e., the entire repertoire of expression by pantomine that frequently speaks louder and more convincingly than words. The patient accurately perceives your attitudes and actions, but inaccurately interprets them according to his own needs and feelings. You may be reacting to a preceding patient, but the next patient will probably interpret it as applying to himself. If you are anxiously beating out an "S.O.S." with your fingers on the desk or doodling with agitation while verbally reassuring a hypertensive patient that his blood pressure is satisfactory, to relax and stop worrying, I can assure you that the

patient will understand what you are doing and reject what you are saying.

Anxiety typically provokes two basic types of reaction, flight or attack. The tendency to flee is occasionally manifested literally by abandonment of the patient, but more typically by denying the existence of the patient's problem. Not infrequently this is the actual explanation behind the diagnosis, "No pathology found." Because of the anxiety provoked by the physician's sensing the presence of the patient's emotional disturbance, but because he feels unable to master the presenting problem, this awareness is pushed back into those recesses of unawareness referred to as the unconscious. To an extent, we see, hear, and feel only what we wish to perceive.

The expression of anxiety through attack is most commonly manifested by hostility toward the patient. Hostility itself in many guises. The attending physician's remark, "That patient, a damn neurotic, nothing wrong with him," patently reveals the anxiety behind this hostile attack. Such a comment is easily interpreted as, "This patient is emotionally disturbed. I feel I can do nothing about it. I am doubtful of my own capabilities. By denying that the patient is sick and depreciating him as being not worthwhile, I feel less threatened." The bombast of the visiting staff, the terrorizer of nurses, and the bane of the resident's life is frequently an anxious individual fearful of his own inadequacies. The patient may be attacked more subtly, more disastrously. Anxiety and hostility in the physician can be most potent iatrogenic agents.

Another common feeling within the physician that is fraught with iatrogenic potentials stems from the doctor's need to receive undue gratification from the patient. The ways in which this need may present itself in the physician-patient relationship are multiple and diverse. Inspection of the physician's careful attention to his patients may reveal that this seeming altruistic attitude is not an expression of his capacity to give but rather of his desire to receive. The unhealthy implications of such an infantile attitude are apparent. Sickness becomes the medium of gratification for the physician. Often where you find an Elizabeth Barrett as a patient you will find a Mr. Barrett as physician. A more common and perhaps less malignant manifestation of the same phenomenon is seen in the physician who cannot accept the least hostility from the patient, for this so threatens his need for love that the protest of rage and indignation thereby provoked clearly resembles the reaction of a child whose immediate desire for gratification is being obstructed, in truth, a temper tantrum. Interestingly, these same dependency strivings may present themselves in quite a different fashion. To defend himself against these urges, the physician reacts in quite the opposite manner. By denying his own needs he also fails to recognize the patient's normal need for dependency support in sickness. This defensive character trait results in some physicians being distant, dispassionate, aloof—the "cold" scientist. Or the patient's dependency may so distressingly activate his own wishes that in denying them he angrily berates the patient with, "a damn baby, acting like a child, et cetera." Then there is the physician whose narcissistic needs dictate that he must preserve the illusion of omnipotence. This is the doctor who plays God and enforces his patients into a status of complete dependency. These are the poor patients who, should they fail to improve, or indeed do not do exactly what the physician says, must bear the brunt of a revengeful Jehovah and assume full guilt for their failure to recover.

In attempting to present a topic of such latitude as the iatrogenic importance of the physician's feelings, attitudes, and behavior in the brief time allotted, I have taken the license of generalization and use of the extreme for illustration, but I have tried to avoid confusing reality with exaggeration. The role of the physician's personality in treatment, like a sword with two edges, may cause as well as cure disease.

References

1. Dorland, W. A. N.: The American Illustrated Medical Dictionary. 20th ed. Philadelphia: W. B. Saunders, 1946.
2. Halliday, James L.: Psychosocial Medicine. New York: W. W. Norton and Co., 1948.

MSMS

UNIFICATION OF HOSPITALS

. . . We propose a unification of the Government hospitals, health service, medical research and guidance to Governmental grants-in-aid to civilian hospitals.

As an indication of waste, there already existed in Federal hospitals, at the time of our investigation, beds for 225,000 patients and only 155,000 were occupied.

Yet Congress had made appropriations for, or authorized, hospitals with 50,000 additional beds despite the fact that 70,000 are empty—at a cost of $1,300,000,000. President Truman canceled out $300,000,000 of this program, and Congress restored the authority.—*Hoover Commission Report.*

Observations on a Recent Journey in Sweden

By B. Hjalmar Larsson, M.D.
Detroit, Michigan

AMERICAN and other visitors to Sweden cannot fail to be impressed by the quality of its medical services in general and its new hospitals in particular. In Stockholm, the capital of the country, with a population of slightly less than 700,000, two new hospitals have been opened to the public during the past decade. They are Karolinska Sjukhuset (the Karoline Hospital), and Sodersjukhuset (the Southern Hospital). Each has a capacity of about 1,200 bed patients.

The Karoline Hospital has attached to it the new buildings of the Radiumhemmet, probably a model to the entire world for the study and treatment of malignant diseases. This department is under the able direction of Professor Elis Bervin, a world-renowned authority on malignancy.

The Karoline Hospital is located in the northern outskirts of Stockholm on a solid rock foundation (granite) and in the center of a wooded plateau comprising an area of about 559,000 square meters (115 acres). There is a special building for medical research, a memorial to King Gustaf V, which has exceptional facilities for such work. It is under direction of the highly qualified internist, Professor Nanna Svartz.

The Karoline Hospital represents the culmination of a lifetime of planning and co-operation between physicians, surgeons, and architects.

To this observer, at least, it would be difficult to find any shortcomings in planning for either efficiency and beauty or economy. The names of Professor Einar Key, surgeon, Professor Gosta Forsell, roentgenologist, Professor Nanna Svartz, internist, and Professor Carl Westman, architect, are probably the most honored in connection with the building of this great institution. I am particularly indebted to Professor Key for a personally conducted tour of the most important buildings. The heads of the departments took great pride in showing their respective domains, and their courtesies were unlimited.

The cost of construction amounts to about 29,000,000 kronor (almost 8,000,000 dollars); the equipment cost was 6,500,000 kronor (about 1,800,000 dollars).

Since the Karoline Hospital receives patients from all of Sweden, including Stockholm, and is entirely a teaching hospital, the cost of construction was borne by the country as a whole, and the city of Stockholm plus such funds as the King Gustaf V Jubilee Fund for medical and cancer research.

The Swedish Parliament has recently granted funds for the construction of a special pavilion for thoracic surgery. The initiative for this construction probably comes from the pioneering work and sensational successes of a brilliant young surgeon, Dr. Clarence Crafoord. His work on malformations of the aorta and larger intrathoracic blood vessels have received universal recognition. Dr. Crafoord has carried on his pioneer work at the old Sabbatsberg Hospital in co-operation with the cardiologist, Professor Nylin. The new pavilion will be part of the Karoline Hospital and will help to centralize the teaching facilities of this institution.

A prominent feature of this hospital is the mortuary with eight small chapels, where dignity prevails and the bereaved families are permitted to view the bodies of the deceased. A larger chapel with an organ may be used for religious services and burials. There are also facilities for baptism of the newborn if the parents so desire. These departments are located in the basement of the main building and are completely isolated from the view and the activities of the clinics and care of the patients. Professor Key took great pride in this detail of a large, modern hospital and the satisfaction it gives to the public in times of human tragedies.

Preparedness for a possible eventuality of air raids or other war activities has been made. Deep subterranean tunnels have been blasted out of the rocky ground, with shelter for personnel and emergency operating rooms. These are not open to visitors.

There are beautiful parks with paths, water pools, and pine trees, making an ideal surrounding for convalescing patients.

On Saturday mornings, promptly at 8:30, the entire staff meets in the Roentgen Department. In the long rows of shadow boxes, films are demonstrated by the roentgenologists to those interested, and are discussed by members of the staff. At 9:00 a surgical conference is held in the large

Dr. Larsson's journey to Sweden was made in September and October, 1948.

amphitheatre. Four fifteen-minute papers, with demonstration of cases, are presented under the direction of the surgeon-in-chief, Professor John Hellstrom.

The amphitheatre seats 200 people. It is very modern in construction, with indirect artificial daylight coming from a large ceiling-cupola. The light is controlled by the speaker who lowers or raises its intensity to suit the occasion. An ingenious device permits the speaker to draw or sketch on paper and to project this on the screen while facing the audience. The paper can be moved back and forth while the speaker makes his points and demonstrations on the large screen. There are no outside windows to confuse the lighting effects.

The largest wards have six beds, three on each side of the room. There are four-bed and two-bed rooms as well and a limited number of private rooms. All beds are provided with an overhead projecting arm with a sling to assist the patient in moving himself in bed. By each bed stands a combination cabinet with feeding table, a reading stand for books or papers, and space for the toilet equipment for the patient. The beds are of special design and mounted on four fair-sized wheels situated near the midsection of the frame. This facilitates moving of the patient to any place in the hospital without the use of stretchers. Each door has an ingenious handle, large and curved upward so that it can be opened by a nurse carrying a tray or instruments by a pressure with the elbow.

Equipment for physiotherapy is abundant, as well as open and closed sunporches.

Well-equipped apartments for nurses or interns are scattered about the grounds. A certain limited number of homes for married house staff is available. Many of the hospital personnel who have special responsibilities live in homes within the hospital grounds.

A silent system of light signals has been installed for intercommunication, with assistance of the Stockholm Fire Department. There are no loud speakers.

Waiting-rooms for the public, snack bars, and other conveniences are very pleasant, and an effort has been made to obliterate any hospital atmosphere.

The staff dining-rooms are pleasant and meals are served smorgasbord style. One buys a metal coupon which entitles the visitor to the meal, with plenty to choose from.

The Karoline Hospital can be reached by bus from the center of the city in ten to fifteen minutes.

On the south mainland of Stockholm, occupying a dominating height of granite rock, lies the new Southern Hospital, which was opened to the public in 1943. The building is practically one large complex under one roof, its building material being yellowish sandstone and brick of the same color. The hospital overlooks the city and can be seen from a great distance. The Southern Hospital, which is a Stockholm City Hospital, has 1,200 beds intended for the treatment of acute conditions or for complicated examinations. From the very beginning, this hospital was conceived as a complete "health welfare centre" and is linked with other medical institutions and those dealing with social welfare. It is not so much intended for teaching purposes as for care of the poor, for accident cases and for traumatic surgery. Practically all medical specialties are represented in care of the sick and in such proportions as has been determined by careful statistical studies.

The construction and equipment of this hospital represents the last word in such efforts. Long and careful studies by architects, medical men, hospital economists, and others culminated in the building of a truly monumental institution.

There are private, semiprivate rooms, and three- and four-bed wards. The chief surgeon, Dr. Palmer, who kindly showed me around, stated that the four-bed rooms were less economical than the six-bed ward in the Karoline Hospital.

Beneath the main building is a complete underground central infirmary blasted in the cliff, with seven to eight meters of prime Swedish granite as roof. Here have been installed wards for about 700 bed patients and further wards and space for walking patients and visitors. There are two complete operating departments with two operating tables in each and space for sterilization, x-ray department, et cetera. The shelter has its own Diesel-engine driven power station and its own water supply from a special well sunk in the rock.

A railway tunnel runs through the cliff, with good emergency facilities in the event that all ordinary entrances are blocked by bombing. The air-raid shelter can accommodate over 2,000 persons.

The highest effectiveness in the care of the

sick has been the guiding principle in the work of designing this hospital.

Close to the hospital, blocks of flats have been erected where the staff of the hospital can rent apartments on favorable terms.

In order to avoid mixing of patients and visitors, there are two separate entrances. Patients are admitted on the ground floor, visitors and staff in the basement. Cloakrooms are located on both sides of the big visitors hall which is estimated to hold about 2,500 persons. Visitors leave their outer garments in the cloakrooms in order not to carry damp garments and the like into the hospital proper. Information service and exhibits concerning social work and other institutions may later be installed in this large hall. There is a special entrance for ambulance patients to avoid mixing of visitors and the sick and the injured.

The maternity department, so susceptible to infection, has been given separate entrance and exit.

The main building has a volume of 450,000 cubic meters, making it the largest building erected in the northern countries. It has nine stories above and three below the ground. Its height above the ground is 35 meters. Altogether, the building contains 5,400 rooms, including cloakrooms, lavatories, et cetera.

For vertical transportation, there are twenty large elevators for the transport of beds. Each can accommodate twenty ambulatory patients as passengers. The total number of elevators amounts to fifty. Chutes care for rubbish, garbage, and soiled linen. The design also includes pneumatic tubes, though these were not installed at the time of my visit.

The professional work performed at these two hospitals is on a very high standard. The leading men have visited the United States and other countries, are leaders in the profession in their respective specialties, and compare well with the world's best. The quantity and quality of reprints of published contributions, which I have received, bear witness to this fact.

There are many old hospitals and clinics scattered about Stockholm where good work is being done, though in less favorable surroundings. The oldest is the Serafimer Hospital, built in 1752 and still very active. Many famous men in our profession have done their work there, for instance, Olof Acrell, Linneus, Key (father and son), Forssell, Johan Berg and Berzelius, to mention a few.

In the city of Gothenburg, the largest port city on the west coast of Sweden, there are several first-class hospitals. In spite of old-fashioned buildings, excellent work is being done here. I should like to mention the work of Sven Johansson in bone surgery and Dr. Einar Ljunggren in urology.

Dr. Johansson was one of the pioneers in using the special nails in fractures of the neck of the femur. His successor is Dr. Gunnar Lauritzen who has been interested in using the marrow nail in the treatment of fractures of the long bones. He recited the story of this new treatment in about 200 cases since 1942. (The treatment originated in Kiel, Germany, in 1941.) He found it especially useful in transverse fractures of the femur, tibia, and humerus, but has also used it in oblique fractures with equally good results, whether compound or simple. He emphasized that this method should be used only in large hospitals with experienced personnel. The results have been good in 80 to 90 per cent of cases, and the great advantage is the considerable shortening of the period of invalidism. Fat embolism has occurred as a complication, but rarely; other difficulties occasionally occur.

Dr. Einar Ljunggren's great contribution is in the treatment of genito-urinary tuberculosis. He combines surgery with a new chemotherapeutic agent known as PAS, or para-amino-salicylic acid. This chemical was developed by Professor Lehman.

The medical treatment is carried on at a sanatorium located in a high wooded area approximately 40 kilometers north of Gothenburg. This sanatorium has about fifty beds and is reserved strictly for genito-urinary tuberculosis cases. It is part of the large Sahlgrenska Hospital in Gothenburg, where all cystoscopic and surgical procedures are carried on. The medical regime is under the direction of a resident physician who combines treatment of the universally accepted type with PAS. Dr. Ljunggren visits once weekly as surgical consultant. He is rather conservative regarding surgical intervention, nephrectomy, and other urological procedures. His results in ulcerative cystitis with bilateral renal tuberculosis are remarkable. He believes that it is of great importance first to try to diminish dissemination of tuberculous infection; second, to attain a better result in urogenital tuberculosis as well as in all other forms of the disease. These patients should not be operated on until a phase of less activity has been

reached, or the disease has become stabilized. The sanatorium treatment is carried out most thoroughly before as well as after surgical interventions. Besides the usual laboratory tests, a new aid has come from France, the Barge-Bourgain reaction. Whenever this reaction is positive, surgery is not undertaken. Dr. Ljunggren concludes by saying that a combination of sanatorium treatment and chemotherapy as well as careful watching of patients with urogenital tuberculosis will facilitate recovery to a very high degree. This applies particularly to the early cases of renal tuberculosis where a mutilating nephrectomy often can be avoided.

Para-amino-salicylic acid (PAS) is administrated in tablet form with or after meals or with a glass of milk. It is not to be chewed, since it is acid and may cause gastric irritation, but is intended to be broken up and absorbed in the duodenum. The PAS treatment should be carried out without interruption for several months. Smaller doses are used in renal than in pulmonary tuberculosis to prevent injury to the kidneys. The sodium salt of PAS is preferable, though it is more difficult to obtain at present and more expensive. The dosage is 8 to 12 gm. per twenty-four hours in four to six divided doses. Routinely 10 gm. are given in six divided doses. However, this is varied according to tolerance. The effect of the drug is noticed in less troublesome cystitis, increase in bladder capacity, and disappearance of tubercle bacilli from the urine. The usual tests, including guinea pig inoculation, et cetera, are the standard for control of the patient's progress during this special treatment.

These observations would not be complete without recording a regular meeting of the Gothenburg's medical society. This was held at a small, private hospital, the Karlanderska Sjukhuset. The assembly hall of this hospital resembles a chapel of pure Gothic architecture. Of the 300 members of the local society, about 100 were present. The scientific program of the evening dealt with alcoholism in Sweden, evidently a rather acute problem. The speakers were both laymen and physicians, including judges and the chief of police. Dr. H. Forssman read a paper on the use of a new Danish preparation, Antabus, against alcoholism. This new drug is administered in pill form in definite doses, the pharmacologic effect of which lasts five days. It is harmless and is eliminated by the bowel. It has been used ten months without harmful effects. In 70 to 80 per cent good results have been reported from Denmark. The case of a young man, an alcoholic, was demonstrated. He had previously received the drug. The speaker treated him to 15 cubic centimeters of cognac from a test tube. In fifteen minutes he returned, feeling nauseated, face red and hot, apparently very ill at ease. A lively discussion followed the different presentations.

Following the meeting, a fine banquet was held at the Palace Hotel, with continuation of the discussion on alcoholism but without any drastic measures taken to prevent it, during that evening, at any rate.

I noticed a great interest and appreciation of American medicine, and had the opportunity to express my gratitude to my Swedish colleagues for their cordial hospitality and generous sharing of experiences.

The Swedish physician is alert, usually speaks good English, and is always proud to show foreign confreres what is being done and to exchange ideas. There are many opportunities for special studies as well as general observation in the management of the sick and needy. The observations recorded here are of necessity brief and general but may be of interest to reveal how a small country of homogeneous population and limited resources, but with very high living standards, is able to provide this most vital service to its people.

TWO MEALS A DAY

When Mary Garden, the famous opera singer of bygone days, stepped off a steamer from Britain recently, her slim, girl-like figure attracted immediate attention. She is seventy-two and weighs only one hundred and twelve pounds. When asked how she kept her weight down, she replied that for thirty years she has eaten no evening meal. Her home is now in Scotland. She came to this country for a lecture tour.

It would be idle to advise all who wish to avoid overweight to follow her example. Very few persons would adhere to her regimen. It is not necessary to eat only two meals daily to keep one's weight down. It is a matter of total daily caloric intake. It is only necessary to reduce the amount of food consumed the first two meals, thus leaving something for the third meal of the day.—*Good Health,* December, 1949.

Rehabilitation of the Hard-of-Hearing School Child

Detroit's Plan

By L. Galdonyi, M.D.
Detroit, Michigan

ACCORDING to reliable estimates, there are about ten million hard-of-hearing adults in the United States. A large percentage of these can trace back the beginning of their hearing loss to childhood. Repeated surveys, conducted in various parts of the country, reveal the fact that about 4 to 6 per cent of all school children have defective hearing. A higher percentage is found in rural districts, a lower one in cities, probably due to better facilities for treatment.

There is a great difference between the hard-of-hearing adult and the hard-of-hearing child. The loss of hearing in an adult is fixed and, with the exception of the fenestration operation by which only a very small percentage of the hard-of-hearing population can be benefited, medical treatment is of little avail. With children this is not the case. Their power of recovery is amazing. However dangerous the popular belief that "the child will outgrow it," there may be some truth in it since spontaneous recovery from almost any disease or deficiency in childhood is not a rarity. Acknowledging this fact, we realize, however, the danger of putting hope in such spontaneous recovery by postponement of necessary treatment. Much valuable time may be lost during which, instead of improvement, the disease or deficiency may have progressed to such an extent that medical treatment can no more achieve a complete cure.

One of the difficulties in establishing necessary treatment of incipient hearing loss is the fact that a hearing deficiency in a child is very often overlooked. The following is an example of such a case:

Jane F. was a fourteen-year-old girl in the ninth grade. All through her school years she was quiet and well-behaved, with a sweet smile and a gentle, pleasant personality. Her teachers liked her so much that they let her pass from one grade to the next in spite of her poor performance. When the time came to promote her from Intermediate to High School, for which she was definitely not fitted, the school counsellor explained to her that she could not be passed with her classmates because her work was not satisfactory. During this interview the girl with tears in her eyes confessed that she could never hear what the teachers were saying in class! This girl had gone through the elementary and intermediate grades without ever being recognized as being hard-of-hearing!

This probably is an extreme case; however, it illustrates how much hearing loss can go undetected in a child.

To prevent such occurrences and to insure every child the maximum benefit of his education, as well as to guide the hard-of-hearing children with relatively slight hearing loss to their physician for an early rehabilitation, the Detroit Department of Health in collaboration with the Board of Education has for many years conducted a hearing survey in the public and parochial schools of Detroit to detect the students with hearing deficiencies.

For screening purposes a mass hearing test is given with the aid of the G.E. 4A Audiometer. This is a phonograph with forty receivers with which forty students can be tested at the same time. On a disc a male and a female voice are recorded speaking numerals of two and three digits. As the record is played, the voice becomes gradually fainter until the normal threshold of hearing is reached. The children are asked to write down these numbers as they hear them. As this test is not given in a soundproof room but in an ordinary classroom, the always present background noises are taken into consideration and a 10 per cent hearing loss is permitted.

All children with a hearing deficiency, as disclosed by the screening tests, are asked to appear with their parents at the Clinic for Hard-of-Hearing Children for extensive individual testing. The clinic is located in the Day School for the Deaf, where specially trained teachers and an otologist conduct the examination. This clinic is purely diagnostic; no treatments are given, but the children are referred back to their physician if treatment is indicated.

At the clinic the history of the child's health is taken, with special reference to heredity and diseases of the ear in order to establish a possible causative factor of the hearing deficiency. One of the standard questions is, "When was the hearing defect first noticed?" The answer to this question, nine times out of ten, is "not noticed." Unless the child has an advanced hearing loss—

usually about 30 to 40 decibels or more—the mother does not realize that her child's hearing is subnormal. And this should not be surprising since we are measuring the normal threshold of hearing to discover a deficiency. But the intensity of the average speaking voice is approximately 60 decibels above the threshold of normal hearing and should be heard at a distance of 80 feet and the whispering voice at 40 feet; and parents, as a rule, do not whisper when talking to their children. Occasionally, a mother will state that her child hears well although hearing tests have disclosed a considerable loss of hearing. Actually, when the mother talks to her child, he will respond like any other child with normal hearing. But when the mother is asked to turn her face away from her child while speaking, the child will not respond. He was lip reading all the time, although his mother was not aware of this fact.

At the clinic the pure-tone audiometer and the speaking voice are used for testing. The great advantage of the audiometer is that we can test with it the whole range of the scale between 128-8192 vibrations. This is important because many a hearing loss starts below or above the range of the speaking voice which is between 512-2048 vibrations. The other advantage of the audiometer is that the intensity of the sound can be increased and decreased at will until the threshold of hearing is found and the result can be charted exactly. The audiometer measures the hearing in decibels.

In order to determine how well the child can hear speech and not pure tone, the audiometer test is followed by the speech test using the quiet conversational voice and the whispering voice. For practical purposes the children are tested from a distance of twenty feet. The ear to be tested should be turned to the examiner and the other ear closed with one finger, precaution being taken to prevent lip reading. If the child does not understand the examiner from twenty feet, the distance between the examiner and the child is reduced until the child can understand the spoken word. To round out this examination the child is tested for his ability of lip reading. Some children are natural lip readers and master spontaneously this art, which for an adult is usually hard to acquire.

When the hearing tests have been completed, the child is examined by the otologist. The advance in therapy is well illustrated in this examination. We seldom see any more large heart shaped perforations of the eardrum following measles and scarlet fever which were so prevalent before the era of chemotherapy. Nerve deafness following diphtheria or meningitis is also very rare. The largest contingent of hearing loss as seen in the clinic is conductive deafness due to infringement of adenoid tissue upon the opening of the eustachian tube.

Of 573 children examined in 1946-1947, 189 had enlarged tonsils and adenoids requiring surgical removal. Only sixty of these were found to have suppurative otitis media, and fifteen children had a nerve deafness. It is remarkable that fully one-third of this group had large tonsils and adenoids. Some fifteen or twenty years ago, the tonsillectomy and adenoidectomy operation was considered a necessary part of a child's experience in America—at least in the cities. Today, it seems that the pendulum is swinging in the opposite direction toward the other extreme and it is often not being performed when needed. Since a normally functioning eustachian tube is essential to good hearing, the removal of the adenoid tissue obstructing the opening of the eustachian tube is the first requisite in the re-establishment of normal hearing. A properly performed tonsillectomy and adenoidectomy operation, when indicated, is the first and most important requirement toward the rehabilitation of the hard-of-hearing child. Therefore, the child with large tonsils and adenoids is advised to have them removed, and the parents are asked to return to the clinic with the child after the operation has been performed to recheck the hearing. It is gratifying in most cases to find a marked improvement of hearing after the operation.

The audiometer charts in Figure 1 illustrate the average case.

Unfortunately this long proven recommendation is not always followed, sometimes with disastrous results, as illustrated in the following case:

R. D., five years old, was examined at the clinic in March, 1944. He had an overall hearing loss of 12 per cent in both ears. His tonsils, adenoids, and cervical glands were greatly enlarged, and a tonsillectomy-adenoidectomy was recommended. Four lears later he was again seen at the clinic with the following report of his teacher: "Attention, poor. Application, poor—does not follow directions. The pupil's social reaction to group activities is poor." He still had his large tonsils and adenoids, and his hearing test at that time showed a

hearing loss of 37 per cent in his right ear and 28 per cent in his left.

According to our experience, some parents misinterpret the widely publicized but still controversial relationship between tonsillectomy and sometimes lymphoid tissue will invade the eustachian tube itself, where it is not accessible to surgical removal. For such cases he recommends radium treatment, which will destroy the lymphoid tissue without any deleterious influence upon the

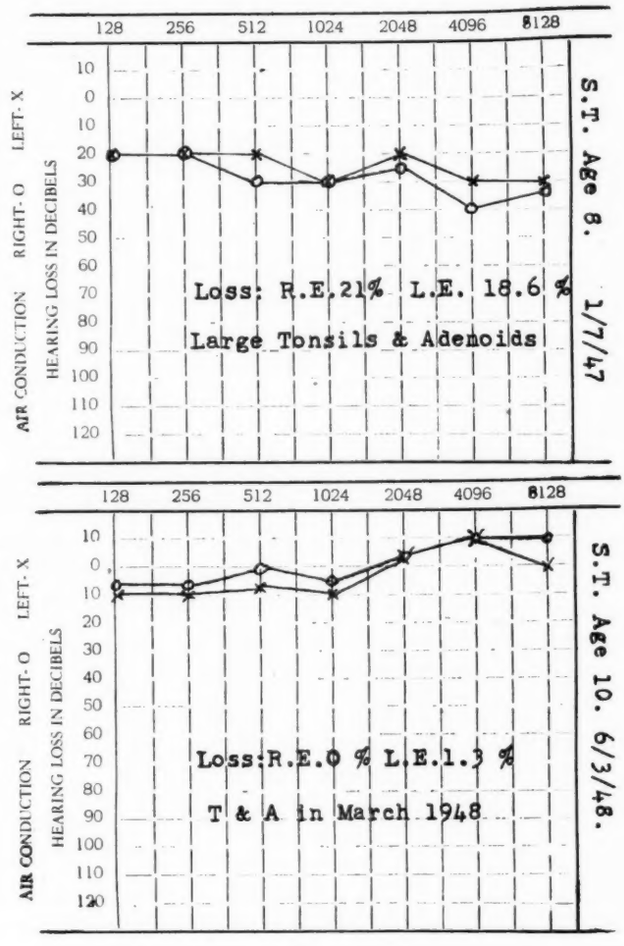


Fig. 1

allergy and that of tonsillectomy and poliomyelitis. They, therefore, reject all suggestions for tonsil operations. And it must be admitted that not every tonsillectomy-adenoidectomy operation will result in an improvement of the child's hearing. Due to the anatomic configuration of the nasopharynx, sometimes even a perfectly performed adenoid operation will fail to remove all the lymphoid tissue around the opening of the eustachian tube. Nasopharyngeal lymphoid tissue is generally recognized as an important factor in the causation of the common cold, acute infections of the middle ear, or hearing loss due to insufficient aeration of the eustachian tube. Crowe of Johns Hopkins calls attention to the fact that surrounding normal tissue. This treatment has been in general use for several years, and there have been excellent results following such procedure where tonsillectomy-adenoidectomy alone failed to clear up the pathologic condition.

In allergic children the possibility of an edema of the mucosa of the eustachian tube has to be considered, and for such children an allergy investigation and vigorous treatment are recommended if allergy is suspected to be the underlying cause of impaired hearing.

As a matter of course, any middle ear infection should be cleared up. In a case of chronic middle ear suppuration, the serious nature of the disease

(Continued on Page 96)

Family Guidance

By John M. Dorsey, M.D.
Detroit, Michigan

"Our increased insight into the importance of the family becomes a responsibility; we must communicate this not only to those who deal directly with emotionally disturbed people, but also to all those who are concerned with making the community a better place for the family to live in, including those in administrative offices." —Helen Ross, *Journal of Social Casework,* February, 1949.

AS THE MEDICAL world has grown older, its theory of health has grown better and a correspondent improvement in its practice of health is observable. During the war military psychiatric screening demonstrated the importance of family living for the mental growth of the individual. Since the war, psychiatry in industry is attesting further the basic significance of family relationships for the development of each family member's mind. The London International Congress on Mental Health was united on the point that the individual's attitudes are based solidly upon his family experiences. The Social Committee of the United Nations General Assembly has taken a position of greatest consequence for our medical world: "The family is a natural and fundamental unit of society and is entitled to protection by society and the state."

This measure of the meaning of "family" is well known to each and every one of our family physicians. The veteran family physician has learned from experience, has had his mind disciplined, to recognize the significance of family living for individual welfare and hence for public health. He is disposed from observation and affection to attend to his patient in terms of the nature and needs of his patient's family. Whether we are ready to recognize it or not, truly it appears that all of us practitioners of medicine are, in a deep sense, family physicians. Whatever we accomplish in terms of any member of a family produces far-reaching effects upon every other member of the family. Every doctor-patient relationship is, by direct extension, a doctor-family relationship.

Research at our Detroit McGregor Center, a hospital for rehabilitation and health education, is clearly demonstrating that the mental organ is critically involved in illness of every other part of the body, and therefore, that psychotherapy is critically involved in all medical practice. By psychotherapy is meant the systematic exclusive use of the *humane* medical presence as therapeutic agent. Our sciences of psychology and of psychopathology have suffered under the inability to localize mental events. Now our accumulating insights made possible by the study of the psychic integrative process, occurring both in treatment and in personality development, can lay this ghost. Man will continue to suffer lying, stealing, killing, beliefs in persecution, and all such self-deception, until his mind grows to attend to the self-reference of all his behavior. Or he will continue the common practice of acting as if he can do the right thing for the wrong reason. Comprehension of the full measure of the meaning of human "individuality" is all we can know, and all that we need to know, for the nicest localizations of all human meaning. The scientific discovery of the localization of mental function and dysfunction, respectively, in mental organization and disorganization explains the difficulties of investigators in mental fact-finding. The investigator's own psychic integration is indispensable to this understanding of the distribution of meanings in the self order.

There is absolutely nothing esoteric, or mysterious, about psychiatric treatment: the medicine of humanity. For example, as a regular accompaniment of all illness aptly called "attacks," the patient is beset by destructive attitudes of disesteem. Thus he is forced to the consideration of a false measure of human worth, thereby suffering the pathological process that is pathognomonic of all mental illness: self-deception. This particular self-deception is of the most disabling kind because it extends over the whole body of the mind, over human individuality itself. Psychopathology may be most accurately defined as the study of imposture; so psychological medicine may be most accurately defined as the love of the truth. For the specific antidote to our general practice patient's abnormally activated feelings of personal unworthiness and insecurity, the physician prescribes his own accurate deep appreciation of human worth. The experienced physician loves his patient as himself and knows that his example is in all of his prescriptions. Such is the nature of specific psychotherapy, whether practiced in general medicine or in psychoanalysis.

Chairman and professor, Department of Psychiatry, Wayne University College of Medicine; director, Child Guidance Division of Children's Fund of Michigan; medical director, McGregor Center, a hospital for rehabilitation and health education.

Investigative studies on general practice patients at McGregor Center reveal the prime significance of family life for individual, and hence, public health. Husband and wife, being their offspring's first physicians, may look to medical education for help in treating him well. The immature mind is most susceptible to demoralization, that ill circumstance of self-disrespect that begets illness.

There is no word of deeper meaning for man than "home," where each of us had his start. The wise old grandmother of one of my friends held that the letters of the word home should stand for "harmony of mind everywhere." Domestic events quicken the interest of every man. Our Emerson long ago claimed that the heroism which would mean the most to us would be that of a domestic conqueror who would show man how to build a wholesome home. Jean Paul F. Richter noted, "Every new educator effects less than his predecessor; until, at last, if we regard all life as an educational institution, a circumnavigator of the world is less influenced by all the nations he has seen than by his nurse."

Let everyone ask himself: what is my idea of domestic well being? Does it depend alone upon wealth? No man in his right mind would make that claim. Certainly a "living wage" is a necessary basis for all living together, and as long as our very livelihood is in question, our self-preservation demands its solution first. Beyond livelihood, what is it that we owe man? We owe man self-growth, self-discovery, self-acceptance, self-realization, self-fulfillment, self-possession. We owe man himself. To quote Emerson once more, "If he is sick, is unable, is mean-spirited and odious, it is because there is so much of his nature which is unlawfully withholden from him." To learn how to help man to help himself is the ideal of the best social service, an ideal that is ineffectual except to the extent that the social worker is able to live it. As Humboldt observed, "The first law of true morality is 'educate yourself' and only its second one 'influence others by what you are.'"

We have never found any other social agency for promoting wholesome self-expression that is an improvement upon the family circle with all of its stirring events. In all of the some 800 peoples of the earth, the family exists as the unit of social life. Find out what kind of a house is kept by a family and you have the best basis for deciding what kinds of citizens that house is producing. Men's minds tend to be as well-arranged and as ill-arranged as the homes they have lived in.

Our American family is the basic unit of our American culture. It would help us most to study each and every home to find what set of attitudes it specializes in. Our progress as a nation among nations depends basically upon the kinds of homes our families operate. Our democratic government, we contend, is preferable to all other kinds of governments in the degree to which it respects the dignity of the individual. By developing "individuality" we mean, specifically, integrating the mind. What is a home for, if not to help every one of its members to grow to full self-respect? Our homes provide the infant and child preschool services indispensable to the cultivation of individuality.

The union of husband and wife makes possible a greater degree than ever of mental integration for each mate. This marital union exists within each mate, not between two creatures. Marriage is the sign of readiness of a man and woman to make considerate service to each other no longer temporary and fitful, but constant. Preparation to be able to take advantage of the integrating opportunities of matehood is an absolute necessity. For the most part this preparation takes place in the home, where each member develops his understanding of manhood and womanhood. Nothing else asks so much of a man and woman as being true mates. Moreover it is impossible to be a good parent except through being able to be a good mate. Striving to be a good husband or wife is the hardest but most wonderful work in the world. This work concerns the progressive cultivation of ever wider ranges of love, most useful exertion that brings with it insight regarding the mutual advantages in sharing. Hence it is that the helpful rather than harmful use of jealousy has such a very powerful role in wholesome family living.

Psychiatrists are frequently asked: where shall we begin in our efforts to raise the level of mental health in the community? The answer is: begin at the beginning—each of us with his own self. The greatest object lesson that our husband and wife can offer their offspring is that of being an effective husband and wife. Thus they revere all humanity. The husband and wife who have been able to respect their own, and hence each other's, selfness, sense the need to revere the individuality of the infant growing to childhood, and thereby

have been able to take the best care of the youngster's growing mind. Children of these mates have been given the best preparation for "taking on" the larger home, the community.

Nothing, absolutely nothing, can ever dim the glory of being human. When psychiatrists try to separate the wheat from the chaff, they find that adult mental health means mental greatness. Mental greatness is the product of mental growth that is self-acknowledged. The psychiatrist does not make the patient great, but rather tries to help him to admit his greatness, to acknowledge his wonderfulness as a human being. The husband and wife who can constantly, and ever tenderly, by their own examples, help their stumbling and falling offspring towards the true assessment of what it means to him to be human, are providing him with all of the mental growth opportunities. Being good to one another is being well with one another. And none deserves so well of the world as a good husband or wife.

There has always been, there is now, and seemingly there always will be suffering in the world. Mental endurance and mental health are closely related. How best to limit suffering and to turn it to account are the problems ever pressing for solution. Death, accidents, operations, illness, divorce, desertion, separation, any and all of the "burdens of existence," may make for the insupportable personal strains in the husband and wife that offer the infant only a hopelessly discordant, a "broken," home. Unwholesome family life provides an apprenticeship for community living that is extremely dangerous.

Husbands and wives do well particularly to ask themselves if their spirit of domination is usefully in mind. Whenever we are not able to be good-natured in our training of children, it is an infallible sign that we need help. Truly, to be able to be "good and angry," both at the same time, requires mental maturity. The need for control, the mastering tendency in human nature, must be constantly under observation. Tyranny, always blind, is the corpse of liberty. And dead liberty is always gangrenous.

The whole idea of domestic service needs to be kept on its strongest foundation, the furtherance of culture through the development of individuals. The home is mental integration's nursery, the cradle of democracy. The democratic husband and wife are the just stewards of the community's youngest fellow citizens. They cultivate the child's "belonging to them" as a step in his learning how to belong to himself in the community. Society needs most the advances in human culture that democratic family organization can bring to it. Society is still sick with many ills of anarchy and tyranny, is still far from the truth of representative government.

The most essential element in any home is love of truth. The habitual, that is, the constant behavior of parents impresses children as truth far more often than do the parents' occasional precepts. It may take rare wisdom to decide, of all that is eternally true, what is also currently good for a human being. In fact, the hardest homework is that of wisely discovering and wisely dispensing truth in terms of the youngster's readiness for it. At last we are instituting family-living instruction in our schools and their extension divisions.

At McGregor Center we are discovering the need to center our health education work in the providing of help to husbands and wives.

All inhumanity of man to man is traceable to self-love, outraged self-love. Only with this insight can mischief be understandable. How to live well is the same idea as how to love well. Love as the guiding principle is the center and circumference of being. Little wonder that the law of loving our neighbor as being ourselves has been unfolded as divine. The only erring thought that acts injuriously upon humanity tissue is hate that is not acceptable to love. The allness of truth demands the allness of love.

The particular size and form of the family and the individual's place in it are consequential. For example, an only child tends to miss companions, the oldest child tends to feel older than his peers in later life, the youngest child tends to feel younger than his peers in later life, the middle child tends to seek attention outside his family; and so on. The "only" boy, the "only" girl, the twin, the step-child, the adopted child—each must contend with his characteristic family living features.

It was said of Israel, "The fathers have eaten sour grapes and the children's teeth are set on edge." Family guidance is of special use because everyone's first reactions to frustrations have primitive elements in them, and the various members of the family are often too near to their trying home situations to get useful perspective upon them, without outside help. Yet, who can deny

that it is dangerously easy to do more harm than good through unfortunately timed and geared community interference with the family? If consecration is not the result of our good intentions, desecration is. The democratic community must respect the individuality of every home or defeat its own purpose. Infant and child guidance necessitate family guidance. Familial equilibrium is maintained in part at the expense of every infant and child and adult in it, and that equilibrium is disrupted by any invaders, for whatever alleged reason. Even the successful treatment of a child upsets the balance of the family and hence calls for special help.

We may be startled by the strength of the health claim for humane behavior, and it is well to ask ourselves why it seems so surprising. Demoralization is caused by ignoring the self feeling that alone can render the help needed. To possess the enlarged power conferred by mental integration is to benefit from the fuller measure of individuality. The healing influence of truth is indispensable for the development of the strength of man's high mental stratum. To ignore it as of little use in diseases is a costly error. Self-reliance is never more needed than during an attack of illness. The only chance that the body has for good government is that its mental part be well. With the most radical reliance on selfness is associated the greatest healing power. Confidence reposed in the power of integration to beget integration needs stronger supports and higher recognition. The only way in which I have been able to help any patient is specifically the way determined by my mind's having been disciplined to fuller acceptance of selfhood than that achieved by my patient. The demands of selfness are mental, and more than all others, the mental agent is related to human progress. The supremacy of the mental part of the body is seldom respected, but only through this discernment can man see himself as unfallen. Human life, manness, is quickened by being recognized. Inaccurate notions of self misgovern respiration, digestion, circulation, metabolism. It is not a decree but rather an observation that the mind forms important conditions of other parts of the body. Is it not understandable that stomach forces might vie with mental forces just as there might be sibling or sibling-parental rivalry?

To acquire experience that is not assimilable as self-experience is to eat the fruit of the tree of false knowledge. A trouble with most of our books on health is that they are not correctly enough centered in self for the reader, and hence further the development of the unreality feelings. What the mind takes in without the self's owning is the material of disease that furthers the morbid process of depersonalization. We are all like Adam, being required to name everything that we observe. When we do not give everything our own name, we lie. The mind can be educated to help rather than harm the rest of the body. Because it holds the issues of life, it is essential that its various functions work harmoniously. It is easy to be misled by what seems for a time to benefit the patient. But self-deceiving mental forces can work only ill effects. When one's false measure of self is corrected, the whole individual receives an access of health. Attention (observation, study, investigation, all individual research) expressed with its true self-reference promotes self-growth. It is a misfortune when self-growth is not the acknowledged benefit of academics of every sort. It is the incorrect view of self that depreciates the importance of truth and accounts for sincerity being most difficult of all.

The general earmarks of the superior family life might be summed up in the following six terms. Superior family life is the product of a husband and wife each trying to grow up enough mentally to be able:

1. To recognize both the greatness of their privileges with each other and the greatness of their responsibilities in terms of each other. Such a husband and wife will realize that their chances for happiness are in each other's hands and that it behooves each most to aim at his own betterment, his own improvement.

2. To recognize self-possession as mankind's greatest good. Self-possession means just what it says: the awareness of possessing one's own self. Such a husband and wife will enjoy beneficial insight about their illusion that their children belong to them. Each member of this family can call his soul his own.

3. To realize that their own mental health is not vouchsafed but must be earned and constantly maintained. Such a husband and wife will use their own precious capacities for truthfulness and dependence to be constantly "on the lookout" for the right kind of help. They will study the facts about how the mind develops and thus

provide a growth medium for their youngster in which to develop mentally.

4. To attend to being both lowly wise and high principled. Such a husband and wife will guide their infants and children to higher levels of genuineness away from the miraged heights of hypocrisy. Such a husband and wife will be aware of the important life forces and interests.

5. To represent examples to their children and community of the humanizing influences of love. Such a husband and wife will constantly nourish and wean their growing offspring to fuller and fuller home-felt, self-felt, appreciation for all that it means to be human.

6. To cherish our democracy because of the principle for which it stands: reverence for the dignity of human individuality. Such a husband and wife, in patterning their home rule after the humanity-representing Constitution of our country, will protect and further the integration of each and every member in the family.

To sum up then, the worst mistake of a home is its inability to respect the true nature and needs of the infant born into it. What makes a successful home is the understanding that Providence intended the growth of the human being from infanthood to adulthood to be the gradual growth that it is, requiring, and thus insuring, the development of great preparation, great love, great patience, great gentleness, great moderation, and great perseverance in the husband and wife.

In conclusion, it is understandable that each one of us husbands and wives daily becomes weary in well-doing. It is disheartening not to be able to see immediate good results of our efforts. Here the psychiatrist can bring us two encouraging and reassuring truths from his experiences. First, it is never too late to start helping ourselves more. Second, a helpful hand is never, not even once, lifted in vain.

JMSMS

THE CONSTITUTION

It has been said "you cannot eat the constitution." Even so, the present plight of European countries, including Great Britain, indicates that you can't eat without it. The constitution was drawn and adopted in order that we might, forever, have turkey for Thanksgiving.—*Journal of the Oklahoma State Medical Society,* January, 1950.

REHABILITATION OF THE HARD-OF-HEARING SCHOOL CHILD

(Continued from Page 91)

should be explained to the parents, and the danger in neglecting the proper treatment not only to the hearing but to life itself should be pointed out in definite terms.

According to the degree of hearing loss, a child may be left in his regular school without or with, if indicated, instruction in lip reading. Lip reading is one of the most valuable aids in overcoming the handicap of hearing deficiency. Since a child learns lip reading so much easier than an adult, the study of lip reading, especially in cases where a progression of hearing loss is possible or probable, is of the utmost importance.

Children whose hearing deficiency has advanced to a point where they cannot make satisfactory progress in regular schools are admitted to the Day School for the Deaf. These children fall into two groups, those who are seriously hard-of-hearing and the totally deaf children. The hard-of-hearing students get their education by utilizing the remnants of their hearing with the help of individual and group hearing aids, through amplification, by stimulating and salvaging the residual hearing, speech training, and lip reading. These children are kept in the Day School for the Deaf only as long as their handicap necessitates special education. As soon as they are able to pursue their education under normal conditions, they are returned to their regular school.

The totally deaf children who have never heard sounds and consequently never learned to talk are taught to speak through the painstaking, ingenious method of oral training. Their educational rehabilitation is in the hands of specially trained teachers who are able to restore these children to normal living.

Conclusion

Many of the pathologic processes in the child may be arrested and complete restoration to normal may result. The physician's function and duty is to recognize the hearing deficiency early and to establish the necessary treatment.

Bibliography

1. Bunch, C. C.: Audiometry. St. Louis: C. V. Mosby Company, 1943.
2. Detroit Department of Health: Report of Audiometer Testing in Detroit Schools Division of School Health Service, Detroit Department of Health.
3. Wishart, D. E. Staunton: Prognosis in the hard-of-hearing child. Laryngoscope, 57:445, (July) 1947.

Personalized Therapeutics

Public demand for medical services has increased markedly during the past half century. The young doctor of medicine no longer waits hopefully for patients through a long "starvation period." While it is still impossible for one to become legitimately wealthy solely through the practice of medicine, every competent physician is assured an ample livelihood if he chooses to apply himself. And without pausing for extensive statistical analysis, it can be stated definitely that this increased public response is due at least as much to a public awareness that more extensive medical services exist today, as to any recent change in number of physicians per capita.

The resulting partial liberation of the doctor from his former status as economic slave to his practice has in turn contributed to the quality of medical services. Increased exchange of technical information and cooperation within the profession as well as improved standards of education and practice are merely two of the more obvious consequences. But the physician must remember that while increasing demands for his attention attest to improved quality in the profession, they are also a tacit warning that improvement must continue.

Possibly the greatest opportunity for immediate medical improvement today lies in what for lack of a better term might be called "personalized therapeutics." Although reasonably precise and scientific methods are more available than ever before in every facet of medical practice, the patient has not forgotten the more comfortable though empirical approach of the family doctor of yesterday. Requirements of modern medicine have decreased time available for becoming acquainted with the individual patient, and specialized medical practice has increased sharply, but treatment of the patient as an individual rather than as a mere pathological condition is still necessary. The doctor of medicine who conveys to every patient an impression of personal interest and understanding, who maintains thorough patient histories, and who diagnoses with extreme care where personal problems may be contributory factors, will reward both himself and his profession.

W. E. Barstow M.D.

President, Michigan State Medical Society

President's

Page

Editorial

GREETINGS FOR 1950

WE WISH a Happy New Year to all of our members and readers. An intensively active year has passed, and it is well to consider the prospect for the year to come.

The year 1949 saw many assaults upon the theory of independent private practice of medicine. They have mostly been weathered. Probably the most dangerous threat we had to face was the President's Reorganization Plan No. 1, which went down to defeat.

Many bills were introduced into Congress, which if enacted into law would have meant taking over in part the practice of medicine as a government function. The major attack, the Administration bill, known for years as the Wagner-Murray-Dingell Program, is not now especially active, but seventeen Federal bills were introduced aiming to set up various phases of the program. Together or separately, they would have accomplished the same purpose.

On the state level, sixteen states had seventy-one bills introduced tending to bring about socialized medicine. Another year's legislative sessions are upon us, both national and state. We know what to look for on the national level because we have been observing that for many years, but on the state level an increase in one year from forty-two bills in 1948 to seventy-one in 1949 points very definitely to the efforts being made to carry out the national Socialism Program of which socialized medicine is just one feature.

For Medicine, the year 1950 must mean a period of vigilence. We must be on the alert, with our eyes on both national and state political activities.

VICIOUS PUBLICITY

DURING the year just passed, we have commented on numerous occasions on the many newspaper and magazine articles, written with great skill, but carrying in their contents an implication that all is not well in the field of medicine, and that socialism in medicine would be good for the people.

Harper's Magazine for November, 1949, contained an extremely libelous article on "The Rise and Fall of Dr. Fishbein." It was a sensational report of the action taken by the Board of Trustees of the American Medical Association in retiring the Editor. We ignored that article, believing that enough bad publicity had been obtained. *Harper's* announced an article for December by the same author, Milton Mayer, "to trace the tortuous path of the A.M.A.'s retreat before the advancing tide of medical insurance plans."

This article has appeared and is one of the most malicious attacks on the A.M.A. and the medical profession in general that we have ever seen. The article is confusing in that it portrays a fight against something that we are not fighting. It fails to point out what medical insurance is, and that there are almost as many different insurance plans as there are advocates. It places the profession against all of them, not against some and for others.

In the first article, the Michigan State Medical Society gets credit for sending a delegation to England to find out at first hand about British state medicine, and "ultimately established a voluntary membership plan for medical care in the state." The second article says, "though the A.M.A. succeeded in eliminating medical provision from the Social Security Act of 1935, the California Medical Society had already established an insurance plan." Also: "Three years ago the Blue Shield plans for limited medical care were started." Twice in the article, the Blue Shield plans are given only three years of existence. What do they think Michigan Medical Service has been doing for ten years?

The *Harper's* article gives an entirely erroneous opinion of the position of the medical profession on the whole plan of medical insurance. It quotes actions of the House of Delegates and the Board of Trustees of the A.M.A. as opposing continuously for many years the medical insurance program, in spite of the fact that the A.M.A. has just issued Bulletin No. 70 by Frank G. Dickinson, Ph.D., "A Brief History of the Attitude of the American Medical Association towards Voluntary Health Insurance," which says the A.M.A.

has never opposed the development of voluntary sickness insurance plans as they exist today.

Quotations in the *Harper's* article are inaccurate. It was the Michigan State Medical Society which at its annual session in 1933 proposed a workable voluntary medical insurance program. This plan was about to be tried by the Calhoun County Medical Society when state officials stopped further action because the plan was counter to the insurance laws of the state. The plan was taken to California by our ex-secretary and became the incentive at least for the California plan established in 1939. *Harper's* used to be an accurate magazine. Some now feel its sensational misstatements make it unworthy of reader notice.

PUBLIC SPEAKING

THE PRESENT interest in social conditions in England makes the story told by a recently returned traveler most stimulating. A recent lecture by a retired professor of English Literature told of the present miserable economic chaos in England. The professor was born in Canada and has taught for forty years. He painted a picture of distress and discouragement under the Socialistic Labor Government now in England. He predicted a new election before July, 1950, and reported the hopes of many Britishers that at least a few seats could be changed from Labor to Conservative and thus force a coalition government.

He mentioned socialized medicine, told of its abuses whereby people have been going to England to get free glasses and free obstetrics. He reported that the program has been so terrifically expensive that the Government is now demanding a certificate of citizenship before anyone can benefit from this "free" treatment. He mentioned that America is paying for this British experiment in socialized medicine, but he made one statement to which we disagreed. He said that the Doctors and Dentists in Great Britain are reaping a great harvest; that their offices are completely filled with patients, that the government is paying them on a fee basis 100 per cent of charges; the same as they were receiving previous to this experiment, which they were not always able to collect.

After the meeting we challenged his figures. He was of the impression that the doctors were collecting regular fees for every service they render in England. He did not know of the panel under which the doctor works or of the payment of fifteen shillings per year per patient. We are reporting this incident because here was a well-trained observer making a shrewd report of socialistic conditions which he was seriously critizing. Yet in the field of medicine, his information was not only inaccurate, but dangerous in its implications when mentioned in public speeches.

Since this editorial was prepared, we have received a letter from the professor as follows:

> "I've read the letter you gave me. It has some valuable statistical information. Thank you for it. My information re the doctor's charges being paid by the government is wrong. I am grateful to you for putting me in the right. I talked with my cousin at Windemere, a University of Toronto orthopedist who is over there for a year's work observing surgical work with children, also with Dr. Hall at Windemere who is an outstanding physician, and who is doing well professionally; also with a Dr. Sofaer, a specialist in psychiatry in London. My impressions came from these three. Hall is making a lot of money, owns an elaborate yacht.
>
> "I shall not include the M.D.'s next time, for I conscientiously do not wish to misrepresent. Thank you for correcting me so unobtrusively."

We believe this story points to a program which, as medical men, we must all be prepared to carry out. We must correct misinformation which is given us and the public in general sometimes, we admit, inadvertently.

SOCIALISM FAILING?

NEW ZEALAND has recently voted against State Socialism after fourteen years' trial and has gone back to a Liberal-Conservative form of Government. The Labor Government has evidently proven too expensive and entirely unsatisfactory. One of the main factors to bring about this change has undoubtedly been the unfavorable reaction to socialized medicine.

Next came Australia where the Labor Party was defeated by a very large margin, thus ending eight years of a Government which was unable to live up to its promises. The former Conservative Premier and his co-workers are now in authority. Here are two nations "down under" which have thrown out State Socialism after a trial of several years. This is a rare procedure, because usually socialistic governments are thrown out by revolution, rather than by vote.

The Great Britain part of the British Commonwealth is due for an election in July, 1950. Britain will then have had a Labor-Socialist Govern-

ment for five years. The medical profession will have been socialized for two years. The experiment in England has not been successful, especially as it relates to medicine. Every health service was to have been free, including wigs, spectacles, false teeth, and medical prescriptions. However, the expenses of providing these "health necessities" were so great that the English are now demanding proof of citizenship for the wigs and spectacles and are demanding a minimum of fourteen cents for each prescription filled.

The socialistic form of government has endured in Germany for eighty years; in France for over twenty years and is quite prevalent in Italy with no signs of change so far. The break in the British Empire "down under" seems to promise that the world is realizing and appreciating the failures of this form of government. Rugged independence, an ability to take care of oneself, and a belief in commensurate returns from one's work and efforts, rather than equal benefits from group efforts, may bring about a future change.

The unfortunate part of British and European Socialism at the present time is that this experiment is at the expense of the United States. We are paying for British socialized medicine. We are paying for the Socialistic Government in France and other countries.

The results of the last few weeks' elections are very encouraging. We hope the crest of Socialism has been reached. We know the Truman Administration is using every devise of propaganda to bring us to a Welfare State. Radio commentators are now charging almost every day that false and unfair methods are used to encourage socialized medicine.

President Truman sent Oscar Ewing to Europe "to study Compulsory Health Insurance in action." The British doctors charge that he made a report in London but admitted he had not visited a single clinic where the plan was being used—just talked with its advocates.

Socialism is hopefully failing abroad—just at the time it is being most forceably advocated for us.

ANNUAL DUES

THE HOUSE of Delegates of the American Medical Association, at the suggestion of the Board of Trustees, amended the By-Laws, eliminating the provision that membership in the County and State Medical Society carries with it membership in the American Medical Association, and substituting the establishment of annual dues, which the member shall pay through the State and County Medical Societies. Delinquency for a year is cause for dropping the name from the rolls of membership, if following a notice of delinquency from the secretary the dues are not remitted within thirty days.

The dues for 1950 are fixed at $25.00, but this may be changed each year as the Board of Trustees may determine. The amount of $25.00, however, is the top limit established. The annual dues for 1950 of $25.00 carries membership, but not Fellowship. Fellowship is issued upon request with the payment of an additional $12.00, for which THE JOURNAL is sent to the Fellow. Every member of a County and State Medical Society who subscribes for THE JOURNAL may have his name placed on the roster of Fellows by request.

There are about 144,000 members, about 72,000 Fellows, but about 138,000 total subscribers to THE JOURNAL. In other words, nearly half of our members subscribe to THE JOURNAL and pay the fee, but fail to become Fellows simply by not requesting that designation when the subscription is sent to Chicago.

MSMS

ON THE RUN . . .

Spinal-cord symptoms appearing in the patient with pernicious anemia constitute a medical emergency.

. . .

Neuroblastoma is the most common neoplasm of the abdominal cavity in early childhood.

. . .

Thyroid compression of the esophagus occurs when the gland is fibrous, hard and invasive or when it is situated substernally.

. . .

While 40 per cent of cases of myeloma have normal serum protein levels, 99 per cent show an elevation of the serum globulin.

. . .

To evaluate completeness of removal of a chorionepithelioma or mole, repeated quantitative urine assays for gonadotropic hormone must be carried out for an extended period.

. . .

When diabetes and tuberculosis co-exist the diabetes is discovered before the tuberculosis in 65 to 80 per cent of the patients.

. . .

Suspect potassium deficiency in the patient who lapses into stupor after partial recovery from diabetic coma, shows diminished muscular tonus and develops shallow, rapid respirations.

WILLIAM S. REVENO, M.D.

Fourth Annual
Michigan Postgraduate Clinical Institute

Book-Cadillac Hotel, Detroit

March 8, 9, 10, 1950

P. L. LEDWIDGE, M.D., Detroit, *General Chairman*

PROGRAM

Wednesday, March 8, 1950

A.M.

8:00 **REGISTRATION—Fifth Floor**

EXHIBITS OPEN—Fourth Floor

FIRST ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

W. E. BARSTOW, M.D., St. Louis, *Chairman*

8:50 **Welcome**

W. E. BARSTOW, M.D., St. Louis
President, Michigan State Medical Society

J. J. LIGHTBODY, M.D., Detroit
President, Wayne County Medical Society

9:00 **"Present Status of the Treatment of Hyperthyroidism"**

GEORGE CRILE, JR., M.D., Cleveland, Ohio
Member of Surgical Staff, Cleveland Clinic

9:20 **"Discussion of Radiation Therapy for Benign Uterine Pathology"**

J. MASON HUNDLEY, JR., M.D., Baltimore, Md.
Head of Department and Professor of Gynecology, University of Maryland School of Medicine and College of Physicians and Surgeons

9:40 **"Management of the Diarrheas of Infancy and Childhood"**

ROCKWELL M. KEMPTON, M.D., Saginaw
Chief of Pediatrics, Saginaw General Hospital and St. Mary's Hospital

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"The Adrenal Cortex in Health and in Disease"**

JEROME W. CONN, M.D., Ann Arbor
Associate Professor of Internal Medicine and Director of Division of Endocrinology and Metabolism, University of Michigan

11:20 **"The Foot in Infancy and Childhood"**

HERBERT W. HARRIS, M.D., Lansing
Attending Orthopedist Sparrow Hospital and St. Lawrence Hospital, Lansing; Civilian Consultant Orthopedic Surgery, Percy Jones General Hospital, Battle Creek

11:40 **"How to Investigate the Allergic Patient"**

HOMER A. HOWES, M.D., Detroit
Private Practice of Internal Medicine and Allergy

P.M.

12:15 **LUNCHEON, Crystal Ballroom, Book-Cadillac Hotel**

G. T. MCKEAN, M.D., Detroit, *Chairman*

1:15 **"X-Ray Diagnosis of Diseases of the Chest"**

LEO G. RIGLER, M.D., Minneapolis, Minnesota
Professor and Chief Department of Radiology and Physical Therapy, University of Minnesota; Chief Department of Roentgenology, Minneapolis General Hospital; Senior Consultant Veterans Hospital, Minneapolis; Consultant USPHS

WM. E. BARSTOW

ROCKWELL M. KEMPTON

JEROME W. CONN

HERBERT W. HARRIS

HOMER A. HOWES

SECOND ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

G. H. SCOTT, Ph.D., Detroit, *Chairman*
Acting Dean, Wayne University College of Medicine

P.M.

2:00 **"Recent Advances in Dermatology"**
FRANCIS E. SENEAR, M.D., Chicago
Professor and Head of Department of Dermatology, University of Illinois College of Medicine

2:20 **"Potassium in Electrolyte Balance"**
ROSS V. TAYLOR, M.D., Jackson
Chief of Medicine Mercy Hospital, Jackson

2:40 **"The Poliomyelitis Epidemic of 1949"**
FRANKLIN H. TOP, M.D., Detroit
Director Herman Kiefer Hospital, Clinical Professor of Preventive Medicine and Public Health, Wayne University College of Medicine

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Comparative Results of Vagotomy and Gastric Resection for Duodenal Ulcer"**
WILLIAM S. CARPENTER, M.D., Detroit
Instructor Clinical Surgery, Wayne University College of Medicine

FRANKLIN H. TOP

4:20 **DISCUSSION CONFERENCE ON CANCER**

Pathology
C. I. OWEN, M.D., Detroit, Moderator
Attending Pathologist and Director Laboratory Grace Hospital, Associate Professor of Pathology, Wayne University College of Medicine

X-Ray
LEO G. RIGLER, M.D., Minneapolis, Minnesota

Surgery
GEORGE CRILE, JR., M.D., Cleveland, Ohio

Gynecology
J. MASON HUNDLEY, JR., M.D., Baltimore, Md.

Dermatology
KENNETH B. MOORE, M.D., Flint
Staff of Hurley and St. Joseph Hospitals; Syphilologist Flint Dept. of Health

Hematology
A. HAZEN PRICE, M.D., Detroit
Associate Physician Detroit Receiving Hospital; Physician Harper Hospital; Assistant Professor Clinical Medicine, Wayne University College of Medicine

Syphilology
FRANCIS E. SENEAR, M.D., Chicago

8:30 **"A Doctor Visits England"**
GROVER C. PENBERTHY, M.D., Detroit
Past President, Michigan State Medical Society
Dr. Penberthy will present facts on his recent visit to the British Isles as a representative of the American Medical Association.

WM. S. CARPENTER

Thursday, March 9, 1950
Book-Cadillac Hotel

A.M.

8:30 **REGISTRATION—Fifth Floor**
EXHIBITS OPEN—Fourth Floor

THIRD ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

W. J. HERRINGTON, M.D., Bad Axe, *Chairman*

9:00 **"Abdominal Pain Without Local Organic Disease"**
WALTER C. ALVAREZ, M.D., Rochester, Minnesota
Senior Consultant in the Division of Medicine, Mayo Clinic; Professor of Medicine, University of Minnesota; Editor of GASTROENTEROLOGY

9:20 **"Surgery of the Breast"**
ROY D. MCCLURE, M.D., Detroit
Surgeon-in-Chief, Henry Ford Hospital, Detroit

9:40 **"Evaluation of Modern Advances in Obstetrics and Gynecology"**
PALMER E. SUTTON, M.D., Royal Oak
Senior Attending Obstetrician and Gynecologist, Woman's Hospital Staff, Detroit; Senior Attending Obstetrician and Gynecologist, Royal Oak General Hospital, Royal Oak

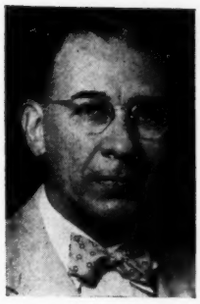
ROY D. MCCLURE

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"The Art of Anesthesia"**
JOE DEPREE, M.D., Grand Rapids
Consultant in Anesthesia, Blodgett Memorial Hospital, Grand Rapids

11:20 **"The Hospital Management of Gallbladder Disease"**
E. THURSTON THIEME, M.D., Ann Arbor
Staff of St. Joseph's Mercy Hospital; Member American College of Surgeons; Instructor Medical School of University of Michigan

11:40 **"The Specificity of the Vitamins and their Proper Clinical Use"**
MARION A. BLANKENHORN, M.D., Cincinnati, Ohio
Director Department of Internal Medicine, Cincinnati General Hospital; Professor of Medicine, University of Cincinnati



PALMER E. SUTTON

P.M.

12:15 **LUNCHEON, Crystal Ballroom, Book-Cadillac Hotel**
(Chairman to be announced)
THE R. S. SYKES LECTURE

1:15 **"Laboratory Methods for the Diagnosis of Malignancy"**
PLINN F. MORSE, M.D., Detroit
Director of Buhl Memorial Laboratory, Harper Hospital

FOURTH ASSEMBLY
Grand Ballroom, Book-Cadillac Hotel

D. R. SMITH, M.D., Iron Mountain, *Chairman*

2:00 **"Essentials in Psychotherapy"**
FRANZ G. ALEXANDER, M.D., Chicago
Director Chicago Institute Psychoanalysis; Clinical Professor of Psychiatry, College of Medicine, University of Illinois

JOE DEPREE

2:20 **"Preventive Pediatrics"**
A. MORGAN HILL, M.D., Grand Rapids
Attending Physician and Consultant Staff of Blodgett Memorial Hospital; Consultant in Pediatrics, Mary Free Bed Guild Convalescent Home and St. Mary's Hospital

2:40—**"The Treatment of Acute Otitis Media"**
JAMES H. MAXWELL, M.D., Ann Arbor
Staff St. Joseph's Mercy Hospital and University Hospital; Professor of Otolaryngology, University of Michigan Medical School

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Ophthalmia Neonatorum"**
WILLIAM L. BENEDICT, M.D., Rochester, Minnesota
Professor of Ophthalmology, University of Minnesota Medical School Graduate Department, Mayo Foundation

A. MORGAN HILL

4:20 **CLINICAL PATHOLOGICAL CONFERENCE**
Pathology
S. E. GOULD, M.D., Eloise, Moderator
Associate Professor of Pathology, Wayne University College of Medicine; Attending Pathologist, Wayne County General Hospital; Editor, "American Journal of Clinical Pathology"
Surgery
DARRELL A. CAMPBELL, M.D., Ann Arbor
Instructor Department of Surgery, University of Michigan; Surgeon, St. Joseph's Mercy Hospital, Ann Arbor
Internal Medicine
MILTON R. WEED, M.D., Dearborn
Assistant Professor of Medicine, Wayne University College of Medicine; Assistant Chief of Medicine, Veterans Hospital, Dearborn

Friday, March 10, 1950
Book-Cadillac Hotel

A.M.

8:30 **REGISTRATION—Fifth Floor**
EXHIBITS OPEN—Fourth Floor

FIFTH ASSEMBLY
Grand Ballroom, Book-Cadillac Hotel

E. C. LONG, M.D., Detroit, *Chairman*

9:00 **"Steroid Hormone in Rheumatic Disease"**
RICHARD H. FREYBERG, M.D., New York City
Associate Professor of Clinical Medicine, Cornell University Medical College; Director of Department of Medicine, Hospital for Special Surgery; Chief of Arthritis Clinic, Hospital for Special Surgery and New York Hospital

S. E. GOULD

9:20 **"Industrial Surgery Is for the Industrial Surgeon"**
J. DUANE MILLER, M.D., Grand Rapids
Chief of Surgery, Blodgett Memorial Hospital

DARRELL A. CAMPBELL

J. DUANE MILLER

REED M. NESBIT

HENRY L. SMITH

9:40 **"The Use of Endocrine Products in Obstetrical and Gynecological Office Practice"**
ROBERT B. KENNEDY, M.D., Detroit
Senior Attending Obstetrician and Gynecologist, Woman's Hospital, Detroit; Head of Dept. of Obstetrics and Gynecology, St. Joseph Mercy Hospital

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"The Use and Abuse of Drugs in Treating Children"**
JULIAN P. PRICE, M.D., Florence, South Carolina
Pediatrician to the McLeod Infirmary, Florence, South Carolina; Consulting Pediatrician to Dillon and Conway Hospitals, South Carolina; Secretary-Editor South Carolina Medical Association; President-Elect, Conference of Presidents and Other State Medical Association Officers.

11:20 **"An Appraisal of Methods for Treatments of Urinary Infections"**
REED M. NESBIT, M.D., Ann Arbor
Professor of Surgery, University of Michigan Medical School; Chief of Urologic Service, University Hospital

11:40 **"Important Concepts in Cardiology for the General Practitioner"**
HENRY L. SMITH, M.D., Detroit
Chief, Division Medicine Mt. Carmel Mercy Hospital, Detroit

P.M.

12:15—LUNCHEON, Crystal Ballroom, Book-Cadillac Hotel
G. C. PENBERTHY, M.D., Detroit, *Chairman*

1:15 **"Treatment of Acute Anuria"**
ISADORE SNAPPER, M.D., New York City
Physician and Director Medical Education, the Mount Sinai Hospital

SIXTH ASSEMBLY

Grand Ballroom, Book-Cadillac Hotel

L. W. GARDNER, M.D., Detroit, *Chairman*

2:00 **"Differential Diagnosis in Diseases of the Upper Abdomen"**
WALTMAN WALTERS, M.D., Rochester, Minnesota
Professor of Surgery, Mayo Foundation, University of Minnesota; Member Board of Governors, Mayo Clinic; President-Elect Interstate Postgraduate Medical Assembly

2:20 **"Bronchiectasis"**
DANIEL W. MYERS, M.D., Detroit
Assistant Professor of Clinical Medicine, Wayne University College of Medicine; Attending Physician, Grace Hospital

2:40 **"Indications for Cesarean Section"**
F. BAYARD CARTER, M.D., Durham, N. C.
Chief of the Department of Obstetrics and Gynecology and Endocrinology, Duke University School of Medicine, Durham, N. C.

3:00 **FINAL INTERMISSION TO VIEW EXHIBITS**

3:30 **"Indications for and Results of Splenectomy"**
FREDERICK A. COLLER, M.D., Ann Arbor
Professor of Surgery and Chairman of the Department of Surgery, University of Michigan Medical School

4:00 **QUIZ PERIOD**
FREDERICK A. COLLER, M.D., Ann Arbor, Moderator
Participants:
F. BAYARD CARTER, M.D., Durham, N. C.
RICHARD H. FREYBERG, M.D., New York City
ROBERT B. KENNEDY, M.D., Detroit
J. DUANE MILLER, M.D., Grand Rapids
DANIEL W. MYERS, M.D., Detroit
REED M. NESBIT, M.D., Ann Arbor
JULIAN P. PRICE, M.D., Florence, S. C.
HENRY L. SMITH, M.D., Detroit
ISADORE SNAPPER, M.D., New York City
WALTMAN WALTERS, M.D., Rochester, Minnesota

END OF 1950 INSTITUTE

After the Institute, Plan on Attending the
MICHIGAN HEART DAY
Saturday, March 11, 1950
Book-Cadillac Hotel, Detroit
(Program follows)

MICHIGAN HEART ASSOCIATION ANNUAL HEART DAY

Saturday, March 11, 1950

Crystal Ballroom
Book-Cadillac Hotel

PAUL S. BARKER, M.D., Ann Arbor, *Chairman*

A.M.

9:00 **Address of Welcome**
WARREN B. COOKSEY, M.D., Detroit
President, Michigan Heart Association

9:15 **"Criteria and Procedures for Diagnosis of Rheumatic Heart Disease"**
HUGH MCCULLOCH, M.D., Chicago, Illinois

HUGH MCCULLOCH

LOUIS V. KATZ

IRVINE H. PAGE

10:00 **"Arteriosclerosis"**
LOUIS V. KATZ, M.D., Chicago, Illinois

10:45 **"Hypertension"**
IRVINE H. PAGE, M.D., Cleveland, Ohio

Noon

12:00 **LUNCHEON**
"Research in Heart Disease, Past Accomplishments and Future Prospects"
PAUL S. BARKER, M.D., Ann Arbor
President-Elect: Michigan Heart Association

P.M.

1:30 **First Annual meeting of members of the Michigan Heart Association, with election of officers**

EXHIBITORS—1950 MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

Company	Booth No.
A. S. Aloe Co.	33
Ames Company, Inc.	19
Baker Labs	12
Bilhuber-Knoll Corp	27
The Borden Co.	13
Camel Cigarettes	28, 29
Ciba Pharm. Products, Inc.	30
Cottrell-Clarke, Inc.	53
Davis & Geck, Inc.	8
Detroit X-Ray Sales Co.	4, 5
Doho Chemical Corp.	49
Farnsworth Labs.	14
C. B. Fleet Co., Inc.	11
Gerber Products Co.	22
Hack Shoe Co.	3
J. F. Hartz Co.	23
Holland-Rantos, Inc.	51
G. A. Ingram Co.	36
A. Kuhlman & Co.	1
Lea & Febiger	41
Lederle Labs	37
Liebel-Flarsheim Co.	16, 17
Eli Lilly & Co.	32
J. B. Lippincott Co.	6
M & R Dietetic Labs., Inc.	35
Maico Hearing Service	40
Mead Johnson & Co.	24, 25
Medical Aids Inc.	20
Medical Arts Surgical Supply Co.	38
Medical Protective Co.	47
Merck & Co., Inc.	39
C. V. Mosby Co.	15
Wm. R. Niedelson Co.	9
Ortho Pharmaceuticals	52
Parke, Davis & Co.	42, 43
Philip Morris & Co., Inc., Ltd.	10
Randolph Surgical Supply Co.	34
Sanborn Co.	31
Sandoz Chemical Works, Inc.	50
W. B. Saunders Co.	2
Schering Corp.	7
G. D. Searle & Co.	45
Sharp & Dohme, Inc.	21
Smith, Kline & French Labs.	44
S. J. Tutag Co.	26
The Upjohn Co.	48
VanPelt & Brown, Inc.	18
Winthrop-Stearns, Inc.	46

THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL POSTGRADUATE COURSES—1950—BRIEF REVIEW COURSES FOR GRADUATES IN MEDICINE

Anatomy	(Thursdays)	February 16-June 1
Internal Medicine		
Diseases of the Gastro-Intestinal Tract		March 13-17
Diseases of the Heart		March 20-24
Rheumatic Disease		March 27-29
Recent Advances in Therapeutics		March 30-April 1
Endocrinology and Metabolism		April 3- 7
Diseases of the Blood and Blood-Forming Organs		April 10-14
Allergy		April 17-21
Electrocardiographic Diagnosis		August 28-September 2
Neurology		May 8-11
Ophthalmology		April 24-26
Pediatrics		April 12-14
Roentgenology, Diagnostic		April 17-21

For further information write to Howard H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, Room 2040, University Hospital, Ann Arbor, Michigan.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

CONFERENCE OF HEALTH OFFICERS

Health officers of Michigan's fifty-four local health departments which serve 93 per cent of the state's population will meet in Lansing, February 8-10, for a major three-day conference to consider future handling of public health programs carried on by local health departments with the co-operation and assistance of the Michigan Department of Health.

State Health Commissioner Albert E. Heustis has called the conference of the health officers, who work directly with the people on health programs, to get their suggestions for the continuation, revision or discontinuation of existing programs and for new programs which should be undertaken.

The Commissioner's Conference, the first of its type in the state, is expected to result in recommendations, not only for what the programs should include, but also how they should be developed.

For the purposes of the conference, health officers of the state have been divided into five committees, each of which is to study, conduct discussions and develop recommendations in specific fields.

Dr. Oscar Stryker, of Macomb County, is chairman of the committee which will consider services such as maternal and child health work, nutrition, geriatrics, accident prevention and school services including the hearing and vision programs. A committee on infectious diseases, including laboratory phases of their control, is headed by Dr. Joseph Molner, of Detroit.

Fiscal policies, fund distribution, formulas for distribution, and methods of securing better financing will be considered by a committee headed by Dr. L. D. Burkett, of Genesee county.

Inter-agency policies between state and local health departments, consultation service policies and qualifications of personnel will be the subject of a committee headed by Dr. Otto Engelke, of Washtenaw County.

Dr. Robert Hall, of Isabella County, is chairman of the committee to consider environmental health programs.

All professional personnel of the Michigan Department of Health will be available as resource people for the conference which will be held in the Department offices, Old DeWitt Road, Lansing.

DOCTOR KENDRICK ACCEPTS WHO ASSIGNMENT

Dr. Pearl Kendrick, Director of the Western Michigan Division of Laboratories, who gained world fame for development of whooping cough vaccine, has accepted temporary World Health Organization assignments in England and in South America.

Doctor Kendrick left in December to spend some time in England helping with the whooping cough study in that country. From England she went to South America where she will do work in connection with the extensive immunization program being planned by the United Nations International Children's Emergency Fund and the World Health Organization.

In South America, she is to work primarily on problems of immunization of children in Chile and Colombia, but she will also survey the public health laboratory facilities in the two countries. The assignments are expected to take two months, after which Doctor Kendrick will return to her duties in Grand Rapids.

CARBON MONOXIDE POISONING

People who ride in some of the newer makes of cars may be poisoned or overcome by carbon monoxide from the exhaust of the car preceding them. This is true in congested traffic or when a car with its motor running is parked ahead of their car. The air intake on air conditioned heaters in some new makes are in direct line with the exhaust of preceding cars.

PUBLIC HEALTH TRAINING

More than eighty University of Michigan graduate students in public health are getting actual health department experience in a training program carried on co-operatively by the University, the Michigan Department of Health and six local health departments which act as training centers.

The graduate students in the School of Public Health are divided into "campus health departments." Each campus department is assigned to a local health department—Barry, Branch-Hillsdale, Calhoun, Eaton or Macomb. The campus group spends one week in the local health department getting a working knowledge of the services of the department. Then the students return to the University where they continue to use statistics and problems of the local health department in their studies. Statistics are provided regularly by the local health department.

This is the third year such training has been provided. Cost-of-living stipends for the graduate students' one week in the local health departments are paid by the W. K. Kellogg Foundation.

NEW BIRTH AND DEATH CERTIFICATES

Beginning January 1, 1950, Michigan, in company with all other states and the signatory nations of the World Health Organizations, began using a new form of registering births, deaths and stillbirths. The new forms which went into simultaneous use are to be standard for the next fifteen years.

A new edition of the *Physicians' Handbook on Birth*

(Continued on Page 108)

NEW BIRTH AND DEATH CERTIFICATES

(Continued from Page 106)

and Death Registrations has been sent to all physicians, funeral directors and health officers. This handbook tells how the new system operates and includes samples of the new forms.

The changeover in Michigan has necessitated the printing of 1,750,000 new birth, death and stillbirth certificates, and the distribution of them to 1,776 local registrars. All old forms have been called in.

Questions regarding the new system or forms should be directed to the Section of Vital Statistics, Division of Disease Control, Records and Statistics, Michigan Department of Health.

NEWS LETTER FOR INSTITUTIONAL FOOD SERVICES

The Section of Nutrition is now preparing and distributing a monthly *News Letter for Institutional Food Services* to state institutions, tuberculosis sanatoria, small hospitals, convalescent homes, county infirmaries, and industrial food services. This newsletter gives buying tips, plentiful foods, low cost foods and how to use them, along with recipes and menus for large groups.

UNTASTY WATER DUE TO NEW PIPES

A petroleum or "chemical" taste in water supplies in new homes or in well-water supplies may be due to a cutting oil used in manufacturing the galvanized pipe or used by the plumber in fitting it. This taste does not make the water unsafe for drinking, but in order to remove the taste and odor, these pipes must be flushed out with hot water or steam or removed entirely.

FOREIGN VISITORS

Recent foreign visitors in the Michigan Department of Health were from Scotland, Tokyo, Ecuador, and the Philippines.

Ann Buchen, dietitian in charge of the 300-year-old, 1,500-bed Royal Infirmary, Edinburgh, Scotland, visited the Section of Nutrition.

Dr. Jevier B. Bustos of Quito, Ecuador, studied the water laboratories.

Dr. Kalsuiji Kato, vice-president of Tokyo Medical College, studied our methods of blood fractionation.

Dr. Demitrio Belmonte of Manila, P.I., visited several Divisions of the Department.

MICHIGAN CHILDREN DENTAL HEALTH DAY

Approximately 1,000 dentists, dental hygienists, public health workers, other medical personnel and lay people are expected to attend the Third Annual Michigan Children's Dental Health Day at Hotel Statler, Detroit, January 30.

National authorities in dental fields will talk on problems related to dental health of Michigan children. The Day is sponsored by the Detroit District Dental Society in co-operation with the Michigan Department of Health and other state agencies.

HOSPITAL GROUP ANNOUNCES SLIDING SCALE TO HELP POORER COMMUNITIES

The office of Hospital Survey and Construction has announced a new "sliding scale" plan of hospital financing, which will enable less wealthy Michigan communities which have need of hospitals to obtain a greater share of federal funds for hospital construction.

Hugh McGoldrick, Director of the Office, reports that the Michigan Advisory Hospital Council has recommended the sliding scale formula for the $2,500,000 in additional hospital funds recently made available to Michigan by federal legislation. Under this formula, the amount of federal money a community can get for a hospital project ranges from 40 to 60 per cent of total cost, depending upon the community's wealth and need as indicated in the equalized valuations (determined by the State Tax Commission) and the hospital need of the community (determined by the Michigan State Plan for the development of a co-ordinated hospital system).

Hospital projects already under construction will not be able to take advantage of the new rule because the new federal law does not carry a retroactive clause, McGoldrick said. Projects now under way will be limited to federal aid of not more than one-third of the total cost in conformity with the original law.

HILLMAN WATER SUPPLY NOW SAFE

The last unsafe water supply of an incorporated community in Michigan was eliminated when Hillman in Montmorency County recently put into service a safe supply.

The Division of Engineering, Michigan Department of Health, which for fifteen years has worked with the community to get a safe supply in operation, in 1945 ordered the community to place in service a safe supply. The order could not be fulfilled because drilling did not reveal a source sufficient to supply the village. After about twenty-five wells had been drilled, two wells with a capacity of 40 gallons a minute each, were developed. While this is a small supply, with the addition of meters and an elevated storage tank, it is adequate to meet the village needs.

PERSONAL ITEMS

Two staff members of the Michigan Department of Health have been named as special consultants to the Communicable Disease Center, Atlanta, Georgia. They are: Russell Y. Gottschall of the Division of Laboratories and Dr. John A. Cowan of the Division of Tuberculosis and Venereal Disease Control.

Other Michigan men among the seventy-three scientific authorities named as consultants are: Dr. C. Eugene Woodruff, Northville; Dr. Thomas Francis, Ann Arbor, and Dr. H. J. Stafseth, East Lansing.

* * *

Norman D. Henderson and William W. Ferguson of the Division of Laboratories, Michigan Department of Health, are co-authors of a paper on "Investigation of Bacteriophage Types D_1 and D_4 HP_{58} of Salmonella Typhi and Tehir Latent Bacteriophage Types" in the November issue of the *American Journal of Hygiene.*

In Memoriam

James Arthur Attridge, M.D., of Port Huron, was born September 10, 1870, at High Gate, Ontario, and was graduated from Wayne University College of Medicine in 1897. Doctor Attridge was a past president of the St. Clair County Medical Society, a life member of the Michigan State Medical Society, a member of the American Medical Association and a Fellow of the American College of Surgeons. He died in Port Huron on May 22, 1949, at the age of seventy-eight.

David E. Bagshaw, M.D., of Saginaw, was born October 10, 1876, at Sunderland, Ontario, and was graduated from the Saginaw Valley Medical College in 1902. He took postgraduate studies at Jefferson Medical College in Philadelphia and also attended the University of Toronto Medical School. Doctor Bagshaw was a past president of the Saginaw County Medical Society, a life member of the Michigan State Medical Society and a member of the American Medical Association. He expired in Los Angeles, California, on March 17, 1949, at the age of seventy-two years.

Corda Earl Beeman, M.D., of Grand Rapids, was born in Naples, New York, in 1874, and was graduated from the Cleveland-Pulte Medical College in 1903 He took postgraduate study in Austria, Switzerland, England, France and India. He was a member of the Kent County Medical Society, the Michigan State Medical Society and the American Medical Association, and was a Fellow of the American College of Surgeons. Doctor Beeman died on May 9, 1949, at the age of seventy-six years in Grand Rapids.

Frank Kelsey Belsley, M.D., of Benton Harbor, was born May 3, 1909, in Peoria, Illinois, and was graduated from Washington University School of Medicine, St. Louis, in 1935. He was a past president of the Berrien County Medical Society, a member of the Michigan State Medical Society and the American Medical Association. Doctor Belsley passed away on May 31, 1949, in Benton Harbor, Michigan, at the age of forty.

Herbert M. Best, M.D., of Lapeer, was born June 10, 1875, at Fingal, Ontario, and was graduated from Wayne University College of Medicine in 1901. Doctor Best served as secretary and president of the Lapeer County Medical Society, was a member of the Michigan State Medical Society, the American Medical Association and at the time of his death in Lapeer, April 28, 1949, was chairman of the MSMS County Secretaries and Public Relations Conference. He was seventy-three years of age.

Kenneth Edwin Blair, M.D., of Detroit, was born May 31, 1910, in San Diego, California, and was graduated from Northwestern University School of Medicine in 1938. He was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. Doctor Blair was thirty-eight years of age at the time of his death in Detroit, on February 28, 1949.

Victor Joseph Blanchette, M.D., of Scottville, was born March 25, 1886, in St. George, Illinois, and was graduated from Chicago College of Medicine and Surgery in 1907. He was a member of the Mason County Medical Society, the Michigan State Medical Society and the American Medical Association. Doctor Blanchette died on May 4, 1949, in Scottville at the age of sixty-three years.

Arthur Francis Boell, M.D., of Grosse Pointe Park, was born in 1895, and was graduated from University of Michigan Medical School in 1921. He was a member of the Wayne County Medical Society, the Michigan State Medical Society, the American Medical Association and was a Fellow of the American College of Surgeons. Doctor Boell died June 21, 1949, at the age of fifty-three.

Jacob Hemans Burley, M.D., of Port Huron, was born August 9, 1877, at Park Hill, Ontario, and was graduated from Saginaw Valley Medical College in 1899. He also attended the Postgraduate Medical School and Hospital in Chicago, Illinois. He had been chairman of the St. Clair County Board of Health since 1943, was a member of the St. Clair County Medical Society and the American Medical Association. He was awarded emeritus membership in the Michigan State Medical Society posthumously at the September, 1949, meeting. Doctor Burley died on August 14, 1949, in Port Huron, at the age of seventy-one years.

Jacob Harold Chalat, M.D., of Detroit, was born in 1888, and was graduated from the University of Michigan Medical School in 1917. He was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. Doctor Chalat died on May 12, 1949, in Detroit, at the age of sixty-one.

Howard Roy Coll, M.D., of Highland Park, was born in Essex, Ontario, in 1888, and was graduated from Wayne University College of Medicine in 1910. He was a member of the Wayne County Medical Society, the Michigan State Medical Society, the American Medical Association and the American Academy of General Practice. Doctor Coll died on October 30, 1949, in Highland Park at the age of sixty-one.

Martha Louise Pomeroy Sanderson Cottrell, M.D., of Novi, Michigan, was born in 1896 and was graduated from the College of Medical Evangelists, Los Angeles,

(Continued on Page 112))

(Continued from Page 110)

California, in 1922. She was a member of the Oakland County Medical Society, the Michigan State Medical Society and the American Medical Association. Doctor Cottrell died at the age of fifty-three, at Novi, on July 8, 1949.

Walter Johnston Cree, M.D., of Detroit, was born in 1861 and was graduated from the Michigan College of Medicine in 1883. He had served as secretary of the Detroit Medical Library Association, the Wayne County Medical Society and the Detroit Obstetrical and Gynecological Society. He was at one time treasurer and historian of the Detroit Academy of Medicine. Dr. Cree was an emeritus member of the Michigan State Medical Society; he was a Fellow of the American Medical Association and of the Association of Military Surgeons. Doctor Cree died on November 9, 1949, in Birmingham, Michigan, at the age of eighty-eight years.

Thomas Edward DeGurse, M.D., of Marine City, was born in Corunna, Ontario, in 1873, and was graduated from Wayne University College of Medicine in 1895. Doctor DeGurse had practiced medicine in Marine City for fifty-four years and was the first recipient of Michigan's Foremost Family Physician award. He served as mayor of Marine City for nine terms. He was a member of the St. Clair County Medical Society, the American Medical Association and was awarded emeritus membership in the Michigan State Medical Society posthumously at its September, 1949, meeting. He had served as Councilor of the MSMS Seventh District for seven years. Doctor DeGurse was also a member of the Michigan Association of Industrial Physicians and Surgeons. He was seventy-five years of age at the time of his death on August 15, 1949.

Arthur Putnam Derby, M.D., of Detroit, was born in 1878, and was graduated from the University of Virginia Department of Medicine in 1904. He was consultant to the Tuberculosis Division of the United States Public Health Service, a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. Doctor Derby expired on June 5, 1949, in Detroit, at the age of seventy-one years.

Bruce Hutchinson Douglas, M.D., of Detroit, was born in Des Moines, Iowa, in 1892, and was graduated from Rush Medical College in 1921. His background was doubtlessly influenced by his uncle who was the famed Dr. Woods Hutchinson, a victim of tuberculosis and founder of Oregon's first health department and tuberculosis sanatorium. Following Bruce Douglas' internship, he joined the staff of Maybury Sanatorium where only two years later he was made medical director. He was appointed Detroit's Health Commissioner in 1941 and devoted his time unselfishly to assist in countless community services which sponsored study and as-

sistance for victims of tuberculosis, poliomyelitis, and cancer, as well as for those who suffered no disease but were victims of racial intolerance and bigotry. He was a member of the Wayne County Medical Society, Michigan State Medical Society, the American Medical Association and acted as delegate to the State Society for many years. Doctor Douglas was killed in an automobile accident near Millington on August 11, 1949, at the age of fifty-six years.

Clement Francis Derezinski, M.D., of Muskegon, was born on January 1, 1912, in Grand Rapids, and was graduated from Loyola University School of Medicine, Chicago, in 1937. He served with the U. S. Navy during World War II, was a member of the Muskegon County Medical Society, the Michigan State Medical Society and the American Medical Association. Doctor Derezinski died of poliomyelitis on August 19, 1949, in Muskegon. He was thirty-seven years of age.

Leslie Higley Stark DeWitt, M.D., of Kalamazoo, was born February 13, 1887, at Spring Lake, Michigan, and was graduated from the University of Michigan Medical School in 1910. He was a member of the Kalamazoo Academy of Medicine, the American Medical Association and a retired member of the Michigan State Medical Society. Doctor DeWitt had been ill since 1943. He died at the age of sixty-two on October 9, 1949.

Alexander Vaughan Forrester, M.D., of Detroit, was born in Victoria, British Columbia, in 1897, and was graduated from McGill University Faculty of Medicine, Montreal, in 1924. He was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. Doctor Forrester was a long-time member of the MSMS House of Delegates. He died at the age of fifty-two on May 10, 1949.

Joseph David Goldsmith, M.D., of Detroit, was born in 1905, and was graduated from University of Michigan Medical School in 1932. Doctor Goldsmith was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. He was forty-three years of age at the time of his death on March 19, 1949, in Detroit.

Burt Francis Green, M.D., of Hillsdale, was born December 16, 1869, at Paw Paw, Michigan, and was graduated from University of Michigan Medical School in 1900. He took postgraduate work at Harvard, the University of Michigan, and at the Mayo Clinic. He served as a Major in the Medical Corps during World War I, and had practiced medicine in Hillsdale since 1906. He was a member of the Hillsdale County Medical Society, of the Michigan State Medical Society and of the American Medical Association. He served as Councilor of the Second District of the State Medical Society for ten years. Doctor Green was a Fellow of the American College of Surgeons and a member of the

Phi Delta Theta Fraternity and the Phi Rho Sigma Medical fraternity. He died on September 26, 1949, in Hillsdale, at the age of seventy-nine years.

Thomas K. Gruber, M.D., of Eloise, Michigan, was born July 4, 1887, in Navarre, Ohio, and was graduated from Western Reserve University Medical School in 1912. He served as a Major in the Medical Corps during World War I, was Treasurer of the Wayne County Medical Society, a member of the Michigan State Medical Society and a Delegate to the American Medical Association. Doctor Gruber had been Superintendent of the Wayne County General Hospital for twenty years and died in his quarters at the Hospital on August 7, 1949, at the age of sixty-two.

Joseph Anthony Haluska, M.D., of Detroit, was born in Great Falls, Montana, February 6, 1900, and was graduated from the Royal Hungarian Peter Pazmany University of Science in Budapest in 1923. He took postgraduate work at the Detroit College of Medicine and in Hungary. Doctor Haulska was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. He died at the age of forty-nine in Detroit, on March 12, 1949.

ORIENTATION COURSE IN CLINICAL ALLERGY

Wayne University College of Medicine Auditorium

Wednesday, January 25, 1950

Chairman: JACK ROM, M.D.
Morning Session—9:00 A.M.

"Basic Concepts of Allergy"—SIDNEY FRIEDLAENDER, M.D.
"Allergic Diagnosis"—HOMER HOWES, M.D.
"Hay Fever and Allergic Rhinitis"—GEORGE WALDBOTT, M.D.
"Bronchial Asthma—Diagnosis"—JACK ROM, M.D.
"Bronchial Asthma—Treatment"—ALEX FRIEDLAENDER, M.D.

Lunch—12:00 M
Afternoon Session—1:30 P.M.

"Aspects of Pediatric Allergy"—SAMUEL J. LEVIN, M.D.
"Allergic Dermatoses—Contact"—LOREN SHAFFER, M.D.
"Allergic Dermatoses—Atopic, Urticaria, and Angioneurotic Edema"—ALEX FRIEDLAENDER, M.D.
"Food Allergy"—HOMER HOWES, M.D.
"Ocular Allergy"—A. D. RUEDEMANN, M.D.
Round Table on "Newer Drugs"—A. FRIEDLAENDER, M.D., S. FRIEDLAENDER, M.D., H. HOWES, M.D., and J. ROM, M.D.

This course, which is sponsored by Wayne University College of Medicine and the Allergy Clinic of Detroit Receiving Hospital is open to all interested physicians.

There will be no fee, but all interested in attending will please register by letter addressed to Dr. Jack Rom, Wayne University College of Medicine, Graduate School, Detroit 26.

. . . . . NEWS MEDICAL

Medical Michigan Authors

The December, 1949, issue of *Archives of Surgery,* contained an article by **James B. Thompson, M.D.; Kenneth F. MacLean, M.D., and Frederick A. Coller, M.D.,** Ann Arbor, Michigan.

The December, 1949, issue of *Surgery, Gynecology, and Obstetrics* contained an article by **W. D. Barrett, M.D.; K. T. Miller, M.D., and C. R. Fessenmeyer, M.D.,** Detroit, Michigan.

The General Practitioner of Australia and New Zealand, in the September number, copied the paper "Early and Late Ectopic Pregnancy" by **Frank E. Whitacre, M.D.,** and **Harvey D. Lynn, M.D.,** which was published in THE JOURNAL MSMS, March, 1949.

The December, 1949, issue of *Bulletin of the New York Academy of Medicine* contained an article by **A. C. Furstenberg, M.D.,** Ann Arbor, on "A Chronicle of One Hundred Years of Otolaryngology."

* * *

In the November issue of *The Journal of the American College of Radiology,* **Sherwood Moore** of St. Louis, urges that industrial and hospital X-ray departments explore more fully the possibility of training blind persons for permanent jobs in darkrooms where X-ray films are processed. He has employed three blind men in his laboratory with success. The employing of blind persons in darkrooms depends upon the selection of suitable individuals and the processing of films in total darkness is desirable.

* * *

Michigan Medical Service, in the first ten months of 1949, expended for medical-surgical services $1,796,000.-00 more than for the year of 1948. The Service has now paid out for services to patrons $37,784,427.04 and for Veterans $3,057,070.28, making a total for both plans of $41,321,397.32. As of November 30 with the final count not yet completed and audited, there were 1,502,000 persons protected by Michigan Medical Service certificates. During the year, Michigan Medical Service has acquired an office building in Detroit, the Burnham-Struble Building, now occupied by the Grand Trunk Railroad headquarters. Michigan Medical Service will be able to occupy this building at the termination of its present lease in the Washington Boulevard Building.

It costs six cents more per month to provide medical and surgical care for single men than for married men. It costs over two and one-half times as much for services to women than it does for services to men.

* * *

E. L. Henderson, M.D., Louisville, Kentucky, President-Elect of the American Medical Association, was signally honored at the recent meeting of the World Medical Association by being chosen President-Elect of that International group. Congratulations, Dr. Henderson, and sincere wishes for a full measure of success in your two important assignments!

* * *

William J. Burns, LL.B., Lansing, has been appointed for the third consecutive year, as a member of the Committee on Medical Jurisprudence of the State Bar of Michigan.

* * *

J. J. Lightbody, M.D., Detroit, President of the Wayne County Medical Society, has been appointed as Chairman of the Wayne County Hospitality Committee for the Fourth Michigan Postgraduate Clinical Institute, scheduled for the Book-Cadillac Hotel, Detroit on March 8-9-10, 1950.

* * *

George C. Stucky, M.D., Charlotte, was recently honored by being elected president of the Michigan Public Health Association at its 1949 Annual Session in Detroit.

Congratulations, Dr. Stucky!

* * *

J. O. Christianson, Ph.D., Superintendent of the School of Agriculture of the University of Minnesota, Saint Paul, Minnesota, has accepted the invitation of President W. E. Barstow, M.D., to be Biddle Lecturer on the occasion of the MSMS Annual Session in Detroit, on September 20, 1950. Dr. Christianson is famed for his informative and witty presentations. He is one of the best and most entertaining platform speakers in the country. His subject will be "Rediscovering America."

* * *

The Conference of Presidents and Other Officers of State Medical Association will hold its sixth Annual Meeting at the Palace Hotel in San Francisco on Sunday, June 25, 1950. For copy of Program write President Clarence E. Northcutt, M.D., 222½ E. Grand Ave., Ponca City, Oklahoma.

* * *

Members of State Board of Registration in Medicine: Cecil Corley, M.D., Jackson; D. C. Eisele, M.D., Ironwood; C. B. Gardner, M.D., Lansing; L. E. Holly, M.D., Muskegon; H. H. McNeil, M.D., Pontiac; Luther Peck, M.D., Plymouth; E. W. Schnoor, M.D., Grand Rapids; R. A. Sokolov, M.D., Highland Park; E. C. Swanson, M.D., Vassar; F. L. Troost, M.D., Holt; and J. E. McIntyre, M.D., Lansing, Secretary.

* * *

Dr. Morris Fishbein retired as Editor of "The Journal of the American Medical Association" on December 1, after almost thirty-seven years of outstanding service. As Editor of JAMA and the nine other scientific pub-

lications of that organization, Dr. Fishbein was recognized as pre-eminent. An editorial commemorating his contributions to health appeared in JAMA of December 10 (Page 1058).

Austin Smith, M.D., who has been associated with the headquarters office of the AMA since 1940, has been appointed Editor to succeed Dr. Fishbein. W. W. Bauer, M.D., Director of the AMA Bureau of Health Education, was appointed as Editor of Hygeia by the Board of Trustees of the American Medical Association.

* * *

The American Medical Association announces that the annual Conference on Rural Medical Service will be held in Kansas City, February 3-4, 1950. Panel study subjects will be five in number:

1. Rural medical facilities at the local level.
2. Relation of Agricultural Extension Service to rural health problems.
3. Community responsibilty for health service in rural areas.
4. Method of pre-payment for health services in rural areas.
5. The responsibility of the medical schools in the rural health program.

* * *

Are You Dieting?—"Everything that is desirable in life is illegal or immoral or fattening."—Saginaw County Medical Society Bulletin (R. D. Mudd, M.D., Editor)

G. C. PENBERTHY

AMA Study in England.—A group consisting of a general practitioner, a surgeon, an internist, a pediatrician, and an industrial physician, just left for England to make a factual study for the American Medical Association of the effect of the Health Act on the people of that country. The personnel of the Committee is:

Grover C. Penberthy, M.D., Professor of Clinical Surgery, Wayne University College of Medicine, Detroit.

Ulrich R. Bryner, M.D., Treasurer, American Academy of General Practice, Salt Lake City.

Walter B. Martin, M.D., member of the American Medical Association Board of Trustees, Norfolk, Virginia.

Heyworth N. Sanford, M.D., Clinical Professor of Pediatrics, University of Illinois College of Medicine, Chicago.

Carl M. Peterson, M.D., Secretary of the American Medical Association Council on Industrial Health, Chicago.

* * *

Labor leaders are beginning to realize that socialized medicine is a threat to the continued existence of unions, AMA President Ernest E. Irons said recently, in addressing the Southern Medical Association meeting in Cincinnati.

"Until recently labor leaders thought they saw in nationalized medicine a potent help in their labor programs," Dr. Irons said, adding: "Labor unions were told

that support of administration measures was to their advantage and was imperative.

"Now, as the picture unfolds, it becomes evident that among the first victims of nationalized medicine would be the unions' own health service. Later, the unions themselves will be destroyed along with business firms in the progressive strangling of free enterprise by the enveloping socialist state.

"English labor unions already have felt the increasing restrictions of a Socialist government. In the propaganda for nationalized medicine in America, union members have been told that this could not happen. A considerable degree of finesse and some time will now be required here by understanding labor leaders to disabuse the minds of their followers of this socialist deception."

* * *

Homer H. Stryker, M.D., Kalamazoo, and **Alfred H. Whittaker, M.D.,** Detroit, were guest speakers on the program of the American Mutual Liability Insurance Company Seminar on Industrial Medicine and Surgery held in Indianapolis on November 30 and December 1, 1949. Dr. Stryker spoke on "Bursitis—Synovitis and Knee Joint Problems" and Dr. Whittaker's subject was "Fractures."

* * *

Domus Medica, International Center of Medical Welcoming Organizations, is occupying a new office at 111 East Oak Street, Chicago; the organization has corresponding offices in principal cities of the world. Physicians may write to the Domus Medica for information or for international contacts, as well as for scientific, cultural, artistic and tourist viewpoints. Physicians who plan to visit a foreign country may contact Valentin Charry, M.D., Delegate of Domus Medica, 111 East Oak Street, Chicago.

* * *

C. E. Umphrey, M.D., Detroit, President-Elect, presented a talk entitled "Medicine, Legislation, Federal Security and Labor" before the College Women's Club of Detroit, December 5, 1949. Mrs. Geo. Zinn was chairman of the meeting.

* * *

Advertised claims that the preparation "Neo-mineral" is effective against stomach ailments, rheumatism, bowel adhesions, and certain other conditions are challenged by Federal Trade Commission in a formal complaint against Neo-Mineral Company, Detroit, and its officers. The Commission also takes exception to representations that the product restores sexual powers, enriches the blood and improves the appetite. The respondents have twenty days to file answer.—Washington Report on Medical Sciences, December 5, 1949.

U. S. Public Health Service grants, recently made through the National Institute of Health, included $10,000 to Harper Hospital, Detroit, for a study of "Psychosomatic aspects of peptic ulcer"; $5,569 to Harper Hospital for a study on "The effect of various regimens on Man-Williamson ulcers"; and $4,644 to Wayne University, Detroit, for a study on "The functional architecture and mechanics of bones."

* * *

The National Heart Institute (of the National Institute of Health—Federal Security Agency) has given the following heart research grants to Michigan agencies: University of Michigan, $96,439; Michigan State College, $5,260; Wayne University, $24,000.

* * *

"Why the private practice of medicine furnishes this country with the finest medical care" is the subject of the fourth annual national essay contest for junior and senior high school students sponsored by the Association of American Physicians and Surgeons. Six national prizes are being awarded: the first, $1,000; the second, $500; the third, $100; the fourth, fifth and sixth, $25 each.

Wilson C. Wolfe, M.D., 360 N. Michigan Avenue, Chicago 1, is chairman of the AAPS essay contest committee.

* * *

The Mississippi Valley Medical Society announces its tenth annual essay contest for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. A cash prize of $100, a gold medal, and a certificate of award is granted the winner—also an invitation to present his contribution before the 15th Annual Meeting of the Society in Springfield, Illinois, September 27-28-29, 1950. Entries are to be received no later than May 1, 1950, and are to be sent to Harold Swanberg, M.D., Secretary, 209 W.C.U. Bldg., Quincy, Illinois.

* * *

Are you getting carbon monoxide from the car ahead of you?—In some new model cars, the fresh air intake for the air-conditioned heater is located in the front fender or grille, directly in line with the exhaust pipe of the preceding car. This intake can and may draw in enough exhaust fumes to endanger occupants of the car. Some automobile manufacturers are taking steps to eliminate the danger.

If carbon monoxide is drawn into your car, your body will absorb it before it absorbs the oxygen in your car; the smaller the person, the more quickly he is affected —a child may become seriously ill of carbon monoxide poisoning before an adult feels it.

Don't get too close to the car ahead of you, and in traffic keep at least one window slightly open to insure a fresh air circulation in the car.

* * *

The Allegan County Medical Assistants Society was organized in October with Ruth DeLockery as president; Nettie Gauthier as vice president; Eleanor Hettinger as

secretary, and Helen Sikorskas as treasurer. The new Medical Assistants Society will meet the third Monday of every month in the Staff Room of Allegan Health Center.

* * *

Recent reprints received: Clifford D. Benson, M.D., Grover C. Penberthy, M.D., and Edward J. Hill, M.D., Detroit, on "Hernia into the Umbilical Cord and Omphalocele (Amniocele) in the Newborn"; Philip Thorek, M.D., Chicago, on "The Fallacy of the So-Called Thyroid Capsule."

* * *

C. E. Umphrey, M.D., Detroit, President-Elect of the Michigan State Medical Society, participated in the WJR radio broadcast "In Our Opinion" on November 27. The general subject of the radio presentation was "Why Socialism Did Not Work in England and Will Not Work Here."

* * *

"Public relations is primarily something you do," states John L. McCaffrey, President of the International Harvester Company, who believes that "only after you have done it, can you talk about it. The words can never be a substitute for the act."

* * *

"It's Different When It Happens to You" is the title of a presentation of Morton Hack of the Hack Shoe Company, Detroit, made before the Detroit Association of Insurance Agents. The following are some clever analogies:

"Look out: it's the doctor this time. Next time, there will be some who will prove to too many of the kind-hearted that the government should operate all shoe stores. Why not? Doesn't everyone need shoes? Weren't shoes the only article of clothing rationed? And isn't it true that many people don't have all the shoes they need? Surely you'll admit that many people can ill afford what shoes they do buy. Many people must wear inferior shoes because they can't afford the best.

"There are too many shoe stores anyway. It is wasteful competition. Under governmental control, we'll have fewer stores, and people will get their shoes free. It is true that they'll have to stand in line for permits, after they produce the necessary documents of necessity with supporting affidavits, notarized, of course, in triplicate. And for Hack Shoes, they'll need certificates in quintuplicate, from three doctors, including one orthopedic specialist, attesting to their degree of disability. Naturally, the rules and required forms will be changed periodically, without notice.

"The State Shoe Stores will be open at specified hours, 10-12; 2-5, no Saturdays or holidays. All those not fitted by 5 will be required to return on the next business day.

"There will be no fitting stools. You will try on your own shoes. There will only be one style. Different styles are wasteful of materials and stock space.

"There will be one shoe fitter to each 15,000 persons. Each State Store will have a manager and an assistant manager as well as two stock men, two porters, two cashiers and two record clerks. Also a stenographer for the manager and a clerk-typist for the assistant manager's office.

"Cities and counties will be subdivided into zones, each of which will have a Zone Supervisory Officer. The Zone Supervisor will have an assistant, two stenographers, three record clerks, three "shoppers" and a maintenance crew consisting of a carpenter, painter, plumber, electrician, heating engineer and their assistants. The Zone Supervisory office will collect and bulk all orders for

replenishing of stock for forwarding to the next higher echelon. This will be repeated at all echelons with a subsequent time lag in transit of all orders of about six months.

"The City or County Director will have adequate staffs, including shoe store architects and a central warehousing executive.

"At the State level, we will have a Managing Director of Shoe Stores for the State. He will be responsible to the Federal Regional Co-ordinator for Shoe Stores who in turn will be under the Federal Director of Shoe Stores, in the Federal Security Agency.

"And everyone will have fallen arches from standing in line to get their shoes.

"Do you really want State Medicine?"

* * *

The Medical Assistants Society of Ingham County has as officers for the current year: Leah Rhoades, president; Roslyn Stadtler, vice president, Mildred Pappas, corresponding secretary; Sally Bennett, secretary, and Mary Lou Howe, treasurer. John E. Sander, M.D., Lansing, president of the Ingham County Medical Society, has appointed an advisory committee to the Ingham County Medical Assistants Society.

* * *

New members of the International College of Surgeons, United States Chapter, who were inducted at the Atlantic City Convocation on November 11, 1949, include the following surgeons from Michigan:

Certified Fellows: Leon Cherest Bosch, M.D., Grand Rapids; W. C. Behen, M.D., Lansing; Walter S. Novak, M.D., Port Huron; Marion Beal Noyes, M.D., Detroit; Constantine L. Oden, M.D., Muskegon.

Advanced to the Rank of Certified Fellows: Alexander W. Blain, M.D., Detroit; Ben F. Glowacki, M.D., Detroit; Clyde Simpson Martin, M.D., Port Huron; Ray S. Morrish, Flint; Jacob F. Wenzel, M.D., Detroit; Thomas Wilensky, M.D., Lansing; and Alfred Heacock Wittaker, M.D., Detroit.

Associates: Leonard C. Blakey, M.D., Monroe; Fred O. Lepley, M.D., Detroit; Frederick Elwin Ludwig, M.D., Port Huron; Russell Earl Lynch, M.D., Centerline; and Alfred A. Thompson, M.D., Mt. Clemens.

* * *

Edward J. Kendricks, M.D., of Alpena, Michigan, has been promoted to the rank of Brigadier General in the U. S. Air Force. He is now Director of Staffing and Education of the newly created Air Force Medical Service. Dr. Kendricks was graduated in 1932 from the Army Medical School and the Army Medical Field Service School; he entered the School of Aviation Medicine in 1934, and joined the Ninth Air Force in Cairo, as surgeon, in 1942. In 1946, General Kendricks became Chief of the Aero Medical Laboratory at Dayton, Ohio. He has been awarded the Legion of Merit with Cluster, the Soldier's Medal, and the Bronze Star.

Congratulations, General Kendricks, of Alpena, Michigan!

* * *

$10,500 to Rheumatic Fever Control Program.—The health of the children of Michigan received a substantial assist from the Arthritis and Rheumatism Foundation and the Michigan Society for Crippled Chil-

dren and Adults, Inc. when these two organizations made grants totaling $10,500 to the Rheumatic Fever Control Program of the Michigan State Medical Society. Announcement of the gifts was made by L. Fernald Foster, M.D., Bay City, Secretary of the Society.

The largest grant, $6,000 from the Michigan Society for Crippled Children and Adults, Inc., was announced by Emmet Richards, prominent Alpena Publisher, and Percy C. Angove, Detroit, President and Executive Secretary, respectively, of the Society. Henry T. Ewald, Chairman of the Executive Committee of the Michigan Chapter of the Arthritis and Rheumatism Foundation, presented the check of $4,500 for his organization.

Dr. Foster, in announcing the gifts, said:

"The life-giving program of rheumatic fever detection centers currently operating in thirty Michigan cities can now be enlarged through the generosity of these grants. In a few short years Michigan has progressed in this program to the point where other states and cities are looking to this Commonwealth for leadership. With the added funds we can go further toward the end of making available to all the people of Michigan the latest findings in the diagnosis of rheumatic fever and arthritis."

* * *

Rheumatic Fever Control Center Chairman, as appointed for the year 1949-50 by the county medical society in which the Center is located (up to December 5, 1949), are as follows:

Center	*Chairman*	*Address*
Alpena	Harold Kessler, M.D.	Alpena General Hospital, Alpena
Bay City	L. Fernald Foster, M.D.	Mercy Hospital, Bay City
Detroit	Norman E. Clarke, M.D.	Wayne Co. Medical Society, 4421 Woodward Ave., Detroit
Grand Rapids	Jerome Webber, M.D.	129 E. Fulton St., Grand Rapids
Jackson	Frank Van Schoick, M.D.	W. A. Foote Memorial Hospital, Jackson
Kalamazoo	H. S. Heersma, M.D.	Bronson Methodist Hospital, Kalamazoo
Muskegon	DeVere R. Boyd, M.D.	1735 Peck St., Muskegon
Pontiac	Donald S. Smith, M.D.	St. Joseph's Mercy Hospital, 900 Woodward Ave., Pontiac
Saginaw	David P. Gage, M.D.	27 Jarvis Yawkey Ct., 217 So. Jefferson, Saginaw

* * *

First Speakers Day Program, held at the Holy Cross Hospital, Detroit, on November 30, 1949, was well attended. The speakers were: Ernest D. Gardner, M.D., Associate Professor Anatomy—Wayne University College of Medicine. Topic: "General Principles of Pain Mechanism," and E. S. Gurdjian, M.D., Professor of Neuro-Surgery—Wayne University College of Medicine. Topic: "Clinical Pain Control." Following the meeting at Holy Cross Hospital, a luncheon with round-table discussion was held at the Whittier Hotel.

* * *

"Parergon," published by Mead Johnson and Co. of Evansville, Indiana, contains in its 1949 edition reproductions of the graphic arts produced by thirty-three Michigan doctors of medicine. The following have been honored by having an example of their artistic avocation published in "Parergon," a word from the Greek meaning "work by the side of work."

W. C. Behen, M.D., Lansing—oil—"Life In Mexico"; Bernard J. Beuker, M.D., East Jordan—oil—"The Janitor's Portrait"; G. Clare Bishop, M.D., Almont—photograph—"Sponge Diver"; Morris Braverman, M.D., Detroit—leather tooling—"Picture Frame"; Philip N. Brown, M.D., Ypsilanti—pastel—"Signorina Superba."

W. Alan Chickering, M.D., Fort Custer—wood carving—"Dorothy"; G. H. Cook, M.D., Ionia—pastel—"Back".

D. C. Durman, M.D., Saginaw—oil—"Lincoln."

Avard Fairbanks, M.D., Ann Arbor—plaster—"Relief, Children of Dr. Furstenburg"; W. W. Fosget, M.D., Lansing—water color—"Pal"; W. M. Foster, M.D., Detroit—photograph—"Glacier Trail".

W. E. B. Hall, M.D., Port Huron—plaster old impression—"Leaf Spray"; Ruth Herrick, M.D., Grand Rapids—photograph—"Rural School"; T. V. Hoagland, M.D., Ypsilanti—water color—"Suspended Animation"; R. K. Hollingsworth, M.D., Ann Arbor—ceramics—"Table Console—3 piece set".

W. B. Johnson, M.D., Detroit—pastel—"West Vidette".

Norman L. Lindquist, M.D., Manistique—photograph—"Iron Ore"; M. B. Llewellyn, M.D., Detroit—needle work—"Coat of Arms".

Hazen L. Miller, M.D., Detroit—oil—"O. P. D."; Sallie W. Miller, M.D., Port Huron—oil—"Eucalyptus—California".

Anderson Nettleship, M.D., Detroit—oil—"Peace, Men Returning From Work".

Charles W. O'Dell, M.D., Ann Arbor—pastel—"Collie"; Constantine Oden, M.D., Muskegon—photograph—"Mary Lind".

Russell Palmer, M.D., St. James—oil—"Winter Landscape"; Hermann Pinkus, M.D., Monroe—color photograph—"At the Old Water Wheel".

Harold F. Raynor, M.D., Detroit—metal art—"Tray"; Francis F. Rosenbaum, M.D., Ann Arbor—photograph—"At Spring Mill".

Arthuur L. Stanley, M.D., Lansing—wood carving—"Human Skeleton"; Bert E. Stofer, M.D., Detroit—photograph—"Snooty".

Julius G. Tapert, M.D., Grosse Pointe—wood carving—"My Wife"; G. W. Trumble, M.D., Mt. Morris—oil—"Returning Spring".

H. F. Warden, M.D., Dearborn—oil—"Marine"; W. H. Winchester, M.D., Flint—photograph—"Portrait in Sanguine".

* * *

Dr. Henry F. Vaughan, Dean of School of Public Health at the University of Michigan, received the Sedgwick Memorial Medal for distinguished service in public health, at the recent APHA meeting in New York.

Congratulations, Dr. Vaughan!

ANNUAL COUNTY SECRETARIES AND PUBLIC RELATIONS CONFERENCE

Book-Cadillac Hotel—Detroit, Michigan

January 22, 1950

THEME—AMERICANISM

Morning Session—10:00 A.M.

"England's Dilemma"—
JOHN B. BENNETT, Congressman, 12th District

"What Do You Know—For Sure?"
(Examination on Socialized Medicine)

Film on "Medical Impractices"
(Also "To Your Health," if time allows)

NOON DAY DINNER (The Italian Garden)—12:00 M

Presentation of Michigan Health Council Award to A. S. Brunk, M.D., Detroit.

"Foreign Aid—Success or Failure"
ROY W. GIFFORD, Borg-Warner International Corporation, Detroit

Afternoon Session—2:00 P.M.

"Americanism vs. Socialism"
(Speech on Congressional situation)
GERALD R. FORD, JR., Congressman, 5th District

Report on Examination
(Question and Answer Period)
Leader: L. F. FOSTER, M.D.,
Secretary, Michigan State Medical Society

Public Speaking Class
PROFESSOR PAUL D. BAGWELL,
Michigan State College

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

FOR THE NEW MOTHER. By Mildred V. Hardcastle, R.N. Illustrated by Shirley Tattersfield. Philadelphia and Toronto: The John C. Winston Company. 1949. Price $2.00.

The young mother will find this book takes her from the very first experiences with the baby, bath, formula, schedule, and then the increased responsibilities and services throughout the first year of the baby's life. The advice is well selected and agreeably presented. This book, in the hands of the young mother, should relieve her mind, be a great help, and make many calls for the doctor unnecessary.

ALLERGY IN RELATION TO OTOLARYNGOLOGY. By French K. Hansel, M.D., M.S., F.A.C.A., Editor-in-Chief, Annals of Allergy; Director of the Hansel Foundation; Associate Professor of Otolaryngology, Washington University School of Medicine. Panel Discussion. Saint Paul and Minneapolis: Bruce Publishing Company, 1949. Price $2.50.

The author presents thirty pages of discussion and very clear exposition of the subject, Allergy in Relation to Otolaryngology. Then follows a panel discussion by nine outstanding teachers and clinicians. Irving B. Goldman, M.D., of New York, believes that infections and obstructive symptoms in tonsils are a positive indication for surgery, even in the allergic child. Kenneth L. Craft, M.D., of Indianapolis, discusses sinuses and nasal polyps. Granville F. Knight, M.D., Santa Barbara, and M. Martyn Kafka, M.D., New York, talk about aviation medicine. Walter E. Owens, M.D., Peoria, Illinois, tells of bronchoscopy and diagnosis of carcinoma of the lung. Hugh A. Kuhn, M.D., Hammond, Indiana, takes the relation of allergy to the ear. Jerome Glaser, M.D., Rochester, N. Y., talks about the treatment of lymphoid hyperplasia. John H. Mitchel, Columbus, Ohio, and Harold A. Abramson, M.D., New York, are also included. This is a very valuable discussion of important and bothersome aspects of the subject.

THE DIAGNOSIS OF PANCREATIC DISEASE. By Louis Bauman, M.D., formerly Assistant Professor of Clinical Medicine, Columbia University, and Assistant Visiting Physician to the Presbyterian Hospital, New York. With a foreward by Allen O. Whipple, M.D. Philadelphia: J. B. Lippincott Co., 1949. Price $5.00.

This monograph discusses the various tests of pancreatic function and their clinical application in the diagnosis of pancreatic disease. Using mecholyl as the stimulant, the pancreatic secretion, free from admixture with gastric juices is collected by means of a conjoined tube, the larger end placed in the duodenum and the shorter end placed in the stomach. Samples of pancreatic secretion are taken at ten minute intervals for one hour, and the fractions, if neutral or alkaline, are tested for volume, amylase, protease and lipase concentrations. This is a time-consuming procedure. However, the author believes it will probably be shortened and become a routine procedure in the hospital chemical laboratory.

The results of approximately 550 pancreatic function

tests have been correlated with findings at operation and/or autopsy. In spite of disturbing limitations, these tests yield information of definite clinical values. Marked diminution of ferment concentration usually indicates widespread disturbance. In acute pancreatitis the serum amylase and lipase values are of greater importance than any other laboratory test. These may however, be elevated in duodenal ulcer penetrating into the pancreas. In twenty-two cases of verified carcinoma of the head of the pancreas, the pancreatic juice was abnormal in twenty (90 per cent) of the cases. In carcinoma of the body of the pancreas, there is usually enough uninvolved tissue to provide a normal secretion.

This is a timely book because, as clinicians, we need any addition to our too few diagnostic aids in the diagnosis of pancreatic disease. As Dr. Whipple states in his foreword, this is a much needed monograph which should stimulate further studies in pancreatic diseases.

L.E.V.

EXTRA-ABDOMINAL CAUSES PRODUCING ACUTE ABDOMINAL SIGNS

(Continued from Page 63)

21. Fitzgerald, R. R.: Differential diagnosis of the cause of recurring abdominal pain in infants and children. Canad. M. A. J., 42:332, 1940.
22. Fries, Joseph H., and Merrill, George A.: Allergic abdominal pain in children. Am. J. Dis. Child., 52:1107, 1936.
23. Gazer, Leslie T.: The cardiovascular aspects of epigastric pain. South. M. J., 29:1101, 1936.
24. Herbert, William P.: Some unusual causes of abdominal pain. Indust. Med., 8:100, 1939.
25. Hinton J. William: Abdominal pain due to hypothyroidism. J.A.M.A., 98:1702, 1932.
26. Ingham, John L.: Abdominal neuralgia in relation to the superficial abdominal nerves. Am. J. Surg., 55:492, 1942.
27. Jayne, Howard, and Jarrett, Edward: Carcinoma of testes presenting as an acute abdomen. Lancet, 1:43, 1943.
28. Keefer, Everett D.: Abdominal pain as a misleading symptom of spinal cord lesions. Am. J. Digest. Dis., 2:520, 1935-36.
29. Lambert, John P.: Psychiatric observations on children with abdominal pain. Am. J. Psychiat., 98:451, 1941-42.
30. Leivy, Frank E., and Schnabel, Truman G.: Abdominal crises in sickle-cell anemia. Am. J. M. Sci., 183:381-391, (March) 1932.
31. McClure, William B.: Effect of acute appendicitis and of lobar pneumonia on the thoracic and abdominal respiratory movements in children. Am. J. Dis. Child., 52:1047, 1936.
32. McDermid, C. E.: The role played by the spinal nerves in functional disturbances of digestion. Am. J. Surg., 16:14, 1932.
33. McMillan, Robert L.; Cowden, F. E., and Reinhart, J. B.: GI symptoms of progressive myocardial disease. Am. Heart J., 29:580, 1945.
34. Mackenzie: Symptoms and Their Interpretations. Ed. 4. London: Shaw and Co., Ltd.
35. Marely, J.: Abdominal Pain, New York: William Wood and Co., 1931.
36. Moore, Matthew T.: Paroxysmal abdominal pain: a form of fecal symptomatic epilepsy. J.A.M.A., 124:561, 1944.
37. Morse, John Lovett: Recurrent abdominal pain in children. J. Pediat., 4:725, 1934.
38. Salzmann, Harry A.: Spontaneous rupture of the heart simulating surgical abdominal disease. Am. J. M. Sc., 188:347, 1934.
39. Snyder, William H.: Abdominal pain simulating acute appendicitis caused by seminal vesiculitis and prostatitis. West. J. Surg., 51:8, 1943.
40. Taylor, Herman W., and Schram, Maxwell: Abdominal symptoms of lead poisoning in children. Arch. Pediat., 53:182, 1936.
41. Walker, Harry: The etiology of abdominal pain in diabetic acidosis. Ann. Int. Med., 9:1178, 1935-36.
42. Witt, W. H.: Abdominal symptoms not due to abdominal pain. Kentucky M. J., 43:137, 1945.

Classified Advertising

CLASSIFIED ADVERTISING RATES

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty.

FOR SALE: Practice and equipment for sale in town of 1,000, centrally located agricultural community, ten-minute drive from hospital. An excellent opportunity for a man finishing training to enter practice at a small outlay. Equipment (including fluoroscope and B.M.R.) to be sold at their depreciated value, which would be under $1,500. There will be no further charge than for equipment. The recently redecorated office consists of four consultation rooms, laboratory, drug and reception rooms, and rents for forty dollars per month. Reason for sale—specializing. Address any inquiries to Box No. 8, 2020 Olds Tower Building, Lansing 8, Michigan.

FOR SALE: Koken combination chair and table complete with stirrups and hydraulic lift. Suitable for doctor or dentist's office. Priced for quick sale. Contact: James E. Bailey, M.D., 73 W. Chicago St., Coldwater, Michigan.

FOR SALE: Established office, one story, ideal location for doctor or dentist. Town of 1,600. For further information write R. Haefner, Broker, or R. E. Orr, Salesman, Decatur, Michigan.

FOR SALE: Used physician's equipment, purchased April, 1948. 1 Cardiatron—direct wiring electrocardiograph; 1 basal metabolism machine—McKesson Metaboler; 1 therapy table—wooden with leather top; 1 Detecto Scales. Also one National cautery purchased 1944. Contact: George R. Landy, M.D., Carsonville, Michigan, Phone 2771, or Sanilac County Department of Health, Sandusky, Michigan, Phone 9.

WANTED: Physician for Village of Wolverine, Cheboygan County, Michigan. Location in heart of resort section in northern lower Michigan. Approximately 500 families in local area needing service. Much greater population during resort months. Hospital facilities near — local factory, expanding — modern school system—good transportation. Contact: Chamber of Commerce, Wolverine, Michigan.

WANTED: Physician for the Village of Bancroft, Michigan. Population about 800 with large outlying district to be served. Hospital facilities about five miles distant. Good housing available. School, two churches, incorporated village, rail and bus lines. Highway M-78 runs through north end of village. Contact Chamber of Commerce, Bancroft, Michigan.

MEDICAL PERSONNEL WANTED: S.E. Michigan Locations. Nurses: anesthetist; operating room supervisor; medical and surgical floors supervisors. Dietitians: administrative and therapeutic. Laboratory technicians: hospitals, research and offices. Medical typists and stenographers for hospitals and offices. Contact Allen Agency, 512 Kales Building, Detroit